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ABSTRACT

This document contains an introduction by Richard D. Krugman and five papers from the Adolescent Sex Offender Work Group meeting, which provide an overview of the present status of treatment programs for adolescent sexual offenders, methodological and ethical issues in research on etiology and treatment, and perspectives on research from those working with these adolescents. Chapter 1, "Recent Developments in the Treatment of Adolescent Sex Offenders" (Fay Honey Knopp), discusses the status of treatment facilities for adolescent sexual offenders in the United States and advocates restorative rather than punitive approaches to adolescent sexual offenders. Chapter 2, "Methodological and Ethical Issues in Evaluating and Treating Adolescent Sexual Offenders" (Judith V. Becker and Gene G. Abel), reports the results of studies on adolescent sexual offenders and discusses problems and ethical issues in doing research on offenders. Chapter 3, "The Adolescent Sexual Offender: Background and Research Perspectives" (Robert E. Freeman-Longo), presents the perspective of one working in a closed treatment facility. Chapter 4, "Adolescent Sexual Offenders: An Outpatient Program's Perspective on Research Directions" (Michael O'Brien), describes an outpatient treatment program and offers a useful classification of various types of adolescent offenders. Chapter 5, "Juvenile Sexual Offenders: A Family Systems Paradigm" (Caren Monastersky and Wayne Smith), reviews some accepted principles in the field, describes one approach to working with adolescent offenders, and provides a sexual offense continuum useful in designing therapy. (NB)

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ADOLESCENT SEX OFFENDERS
Issues in Research and Treatment

A Research Monograph from ncpcr
National Center for the Prevention and Control of Rape

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

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edited by

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and Control of Rape
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PREFACE

Over the past few years the seriousness and extent of the problem of sex offenses committed by adolescents have begun to be recognized by mental health professionals and paraprofessionals, juvenile justice and correctional system professionals, researchers, and policymakers. Although the number of programs designed to treat adolescent sex offenders is rapidly increasing, there is, as of yet, little research or treatment literature for professionals to draw upon in understanding the etiology of the problem and identifying the population at risk, in selecting and assessing the effectiveness of alternative intervention and treatment strategies, or in formulating and implementing policies affecting this population.

This monograph is intended to begin to fill this gap by presenting discussions of the current state of knowledge with regard to causes and treatment alternatives; methodological considerations to be addressed in designing program evaluations and research; and research questions of greatest salience to those delivering treatment and mental health services. The papers presented in this monograph reflect authors' opinions and conclusions based on their extensive experience as researchers and practitioners working with adolescent sex offenders.

The success of the Adolescent Sex Offender Work Group meeting at which these papers were first presented is in large measure due to the efforts of the coeditor of this monograph, Gail D. Ryan, Facilitator of the Network of Professionals Encountering Adolescent Perpetrators of Sexual Molestation of Children, C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect, 1205 Oneida Street, Denver, Colorado 80220.

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ADOLESCENT SEX OFFENDER WORK GROUP

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INTRODUCTION

On May 23, 1984, the C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect and the National Center for the Prevention and Control of Rape hosted a work group on adolescent sexual offenders at Keystone, Colorado. Five papers were commissioned for presentation, providing an overview of the present status of treatment programs for adolescent sexual offenders, methodological and ethical issues in research on etiology and treatment, and perspectives on research from those working with these adolescents in both ambulatory and residential settings.

In the first chapter, Fay Honey Knopp, of the Vermont Prison Research Education Action Project (PREAP), provides an overview of the status of treatment facilities for adolescent sexual offenders in the United States. She points out that the number of treatment programs is far outdistancing the research data on which such efforts should be based. She also plants herself firmly on the side of restorative rather than punitive approaches to adolescent sexual offenders.

Judith V. Becker and Gene G. Abel report on the results of carefully designed studies to assess the magnitude of the problem. The data on the numbers of sex crimes committed by adolescent and adult offenders are staggering. Becker and Abel also discuss the problems of classification, defining normal versus abnormal adolescent sexual behavior, and some outcome studies on adult offenders and then describe the ethical issues that arise in doing research on offenders.

Robert E. Freeman-Longo presents the perspective of one working in a closed treatment facility at the Oregon State Hospital. He again points out that most adult sexual offenders began their "careers" in adolescence and that many adolescents pass through a juvenile justice system revolving door, often having their sexual deviancy unrecognized. He finds both prior abuse and "deviant thinking patterns" in his patients. He suggests that research on etiology is most crucial and would focus on prior abuse, parental bonding, role modeling, social skill deficiencies, emotional development, thinking patterns, sexual

development, moral development, self-concept, value structures, social relatonships, and deviant cycles of arousal patterns among others. Areas of research in treatment issues are also discussed.

Michael O'Brien then describes an outpatient treatment program (PHASE--Program for Healthy Adolescent Sexual Expression). He also offers a useful classification of various types of adolescent offenders: Naive Experimenters, Undersocialized Child Exploiters, Sexual Aggressives, Sexual Compulsives, Disturbed Impulsives, and Peer Group-Influenced Offenders. These are clinically based distinctions; and once again, although believing the PHASE treatment approach is working, he leaves us with the "need for rigorous research."

Caren Monastersky and Wayne Smith, of the University of Washington Juvenile Sexual Offender Program, review some accepted principles by those working in the field: first, that there are many types of offenders; and second, that there are strong family influences on the development of this behavior. They describe the Seattle approach and provide a "sexual offense continuum" that has been useful in designing appropriate therapy.

In approaching these papers it is clear that the participants of this conference have a bias—that adolescent sexual offenders should be approached from a restorative rather than a punitive posture.

Discussion

Unanimity exists on certain issues that need to be addressed by researchers in the field:

- We must have a better classification or taxonomy. "Sexual abuse" or "sexual offender" does not adequately describe the complexity of offenders and offenses.

- We need normative data. What are the limits of "normal sexual exploratory behavior" in adolescents?

- Incidence data are totally inadequate. We need better data and better reporting systems.

- Longitudinal and other approaches are needed to define the "natural history" of adolescent sexual offenders.

  - What are environmental influences?
  - What are family influences?
  - Are there biologic influences?
  - Is there a "critical event"?

- Treatment programs need to be evaluated for outcomes.

- Techniques and methodologies being used in the field need to be validated.

It is clear that many professionals are ignoring the seriousness of adolescent sexual offenders, while those who recognize the problem are "flying by the seat of their pants." The relative lack of data can lead only to problems if not corrected, but the "youthful nature" of the field is a big stumbling point.

Each year should improve our recognition and management of the problem.

Most importantly, even though all adolescent offenders may not be treatable, many are; and it appears to be the best chance we have as a society to have a significant impact on future incidents of sexual exploitation.

We will know more next year.

Richard D. Krugman, M.D.

CHAPTER 1

RECENT DEVELOPMENTS IN THE TREATMENT OF ADOLESCENT SEX OFFENDERS

Fay Honey Knopp

It is exciting to be involved with the C. Henry Kempe Center's efforts to facilitate the treatment of adolescent sex offenders. In 1975, when the Prison Research Education Action Project (PREAP) first surveyed treatment programs for sex offenders and interviewed untreated, incarcerated sex offenders, we found that many of these men had themselves experienced great pain and emotional and economic deprivation. As children, they had often been victims of physical and/or sexual abuse. Imprisonment was the least appropriate intervention for helping them break their cycle of violence.

We also discovered there was appallingly little research that justified the scope and severity of prison punishment as it was--and is--automatically used by the criminal justice system. The fact that no coherent body of literature or system of thought advocating more restorative social practices had yet been developed attested to society's ready acceptance of violent, punitive methods for altering behaviors that were themselves violent. Thus, it was thrilling to encounter for the first time the writings of Brandt Steele and C. Henry Kempe, which advocated nonpunitive and restorative approaches to child batterers. Kempe said that helping such parents to become adequate moms and dads had been successful: "We have had very good results...by protecting them from this old system of crime and punishment" (Knopp et al. 1976, p. 54).

The "old" system of punishment does not benefit society. On the contrary, it causes further harm by contributing to the offender's violent behavioral cycle, already fueled by cultural, familial, and societal patterns. The recognition by child advocates, such as Kempe and Steele, that human needs are met best through restorative practices serves as a useful model for our involvement with

"new" responses to the sexually aggressive behaviors of adolescents.

The public's increasing awareness of and concern for victims of sexual aggression are encouraging developments; however, the public is not well informed about perpetrators of sexual abuse and is even less knowledgeable about adolescent perpetrators. Our work of restoration, therefore, goes hand in hand with educating people about the issues involved in these behaviors. This is a difficult task. Although practitioners are aware that the sexually offensive and violent behaviors of adolescents are widespread and serious, the problem has generally been hidden and thus ignored and neglected (Knopp 1982, pp. 4-9).

Adolescent sex offenses are significantly underreported in official data, not only the most serious crimes of rape but especially offenses involving the molestation of children (Knopp 1982, pp. 9-12). The amount of systematic research on this issue has been minimal. From State to State and in official record keeping, legal definitions of sexual offenses are not standardized. Marked differences exist in the procedures of reporting offenses and the frequency of offenses; and in the absence of any adequate typologies of sex offenders, such offenders are often viewed erroneously as a homogeneous rather than an extremely heterogeneous group. The development of a scientific understanding of adolescent sex offenders would now be greatly aided by treatment providers' willingness to work together to standardize and classify adolescent offender characteristics and histories, their offenses, various treatment approaches, and outcomes. We need to design some simple instruments to accomplish these important tasks.

Despite the lack of coherent theoretical models and problems of definition, treatment programs for adolescent sex offenders are multiplying so rapidly that it is difficult to report accurately on their numbers and even more challenging to report on their quality. I discuss what we have learned at PREAP about recent developments in this burgeoning discipline. Since it is by no means an exhaustive account, I invite you to add to this information.

I report briefly on the ten following issues:

1. some figures on the numbers of programs and services for adolescent sex offenders identified by PREAP

2. the importance of new data from the New York State Psychiatric Institute that support the rationale for early intervention

3. the importance of evaluation and assessment in determining community risk

4. the development and functions of networking

5. evidence of progress in statewide planning for services

6. community-based treatment programing, including an example of a program with a strong focus on positive sexuality and family work

7. the implications of housing adolescent sex offenders in separate units or cottages in residential programs

8. the needs of a neglected population, low-functioning or mildly retarded adolescent sex offenders

9. the need for a training capability

10. a few examples of treatment success in terms of reported recidivism

Growth of Adolescent Treatment Programs

Until the fall of 1975, when the University of Washington School of Medicine's Adolescent Clinic was asked to evaluate and treat a group of adolescent sex offenders from all over the State, evaluation of sex offenses and treatment for this age group had not been undertaken in the United States in a coherent and comprehensive fashion (Brecher 1978, pp. 33-36; Knopp 1982, p. 39). Since that time, treatment programing for adolescent sex offenders

has increased steadily and is evolving rapidly into a highly specialized discipline. PREAP's current listing of treatment providers for adolescent sex offenders (see appendix A), although far from exhaustive, reflects the unprecedented growth of treatment for these people. Identified are 41 residential programs with specific groups for sex offenders, 112 community-based programs offering group and individualized treatment, and 75 programs providing only individual treatment. In addition to these 228 service providers, several dozen other programs are under development. Adolescent sex offenders are also treated in traditional, mixed-offense therapy groups, a practice that most specialists consider less effective than using offense-specific groups.

PREAP has not been able to locate any specialized adolescent treatment programs in 10 States,[1] though efforts are underway to develop services in some. States with the greatest number of identified services for this clientele are Washington (45), California (31), Minnesota (22), and Oregon (13). Ten States[2] and the District of Columbia are listed as providing one such service each.

In addition to a greater awareness of sexual victimization, there are many other reasons why adolescent sex offender services have increased: (1) the availability of more descriptive literature about treatment programs for this age group; (2) the dedication of human service providers to filling a felt need, even though additional resources may not be available; (3) the willingness of treatment providers to train others; and (4) the gradual recognition of the need for early intervention with this age group by key

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[1]Alabama, Arkansas, Kentucky, Mississippi, New Hampshire, North Carolina, Tennessee, Vermont, West Virginia, and Wyoming.

[2]Alaska, Connecticut, Delaware, Georgia, Indiana, Louisiana, New Mexico, Ohio, Rhode Island, and South Carolina.

actors in the mental health and criminal justice systems and by staff of victim assistance programs.[3]

New Data Supporting the Rationale for Early Remedial Intervention

The rationale for treatment of adolescent sex offenders is laid out clearly in two PREAP publications: Remedial Intervention in Adolescent Sex Offenses: Nine Program Descriptions (Knopp 1982) and A Preliminary Survey of Adolescent Sex Offenses in New York: Remedies & Recommendations (Jackson 1984). These include such issues as the early onset of these behaviors, the potential for increase in both the severity and number of offenses by some sex offenders as they grow older, the multiplicity of sexually deviant behaviors practices by a single offender, and the economy of early intervention. Studies cited (Groth 1981; Groth and Birnbaum 1979; Groth et al. 1982), while empirically important, rely on samples of incarcerated adult rapists and child molesters. These retrospective self-reports may not reveal the full extent of the incarcerated offenders' histories and sexually aggressive behaviors, for many reasons. Their admissions of sexual criminality might incur new charges, be added to their records, or contribute to the denial of parole or release. However, recent studies by Abel, Mittelman, and Becker (1984), of the New York State Psychiatric Institute, provide new and startling data that should be integrated into presentations made to legislatures, decision-making bodies, and funding agencies when funds are requested for treatment or research programs for adolescent sex offenders.

These data will be reported in more detail by Judith V. Becker. The information is important not only for its substance but also because of the circumstances under which it was collected. A system of strict confidentiality was

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[3]In a recent PREAP survey (Thompson 1984, appendix B, this volume) of 56 family treatment programs for incest, 23 of 26 programs that presently treat adolescent sex offenders indicated that the need for such programing emerged as a result of treating the incestuous family and discovering one or more adolescent members acting out sexually.

employed with sex offenders who volunteered for outpatient programs in Memphis, Tennessee, and in New York City over a period of 12 years. A few pieces of information from this very compelling research follow:

1. These data support the view that offenses increase remarkably as the sex offender grows from youth to adulthood. Of 240 youths under age 18, each had an average of 6.75 victims as a youth compared to an average of 380 victims as an adult, an increase of more than 55 times as many victims.

2. These data support the view that sex offenses are vastly underreported in official statistics, particularly as they relate to child molestations. Data on 232 child molesters whose victims were less than 14 years of age revealed that they attempted a total of 55,250 molestations and completed 38,727. Their total number of victims was 17,585. They averaged 238 attempted and 167 completed child molestations each. Their average number of victims was 75.8 each.

3. These data support the notion that a sex offender is often involved in a number of different types of paraphilias. Nearly 50 percent of the persons in this study had multiple deviations. For instance, of the child molesters, almost 17 percent were involved in rape, 30 percent were exposing children and adults, and 22 percent were involved in voyeurism and frottage. Of rapists, more than 50 percent were involved with child molestation, more than 11 percent were sadists, 29 percent were exhibitionists, and 20 percent were voyeurs. Thus, Abel et al. (1984) suggest that interviews with clients include questions about activities other than the presenting behaviors.

4. These data confirm that the age of onset of these behaviors is very early. Forty-two percent of the paraphiliacs had deviant arousal by age 15 or before and 57 percent, by the age of 19 or before. The paraphilia with the earliest onset was attraction to little boys (same-sex pedophilia). Fifty-three percent reported arousal by age 15 and 74 percent by age 19.

> Since these are crimes that begin at a very early stage, we have to develop a system that allows us to access these adolescents earlier, because

> most of these people develop arousal patterns far anterior to their actually committing the crime. Many potential paraphiliacs have deviant interest and fantasies when they are 12 or 13 years of age, but have yet to commit a crime. If we are able to stop child molestation and rape, we should treat such young people before the deviant behavior becomes reinforced and habitual. [Abel et al. 1984, p.6].

These reports also include data that reinforce the view that child molestation is much more frequent than suggested in the literature in cases where the target was a male child outside the family. These offenses by men against young males suggest that much greater and earlier efforts need to be made to intervene with these molesters and that victim services must be made available for young male victims.

New data from the Hennepin County Home School's Sexuality Therapy Group (Haversack 1984) reflect similarly high incidences and varieties of sexual offenses among their residential sex offender population.[4] These adolescents reported anonymously on the number of times they engaged in specific types of behavior (there is no way of knowing whether it was with the same victim). Rape is defined as penetration of the vagina or mouth with the penis; indecent liberties are short of that type of penetration, though they may involve digital penetration:

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[4]Hennepin County Home School's reports of the incidence of sexual offenses by a single perpetrator may be much higher than those in similar residential programs for adolescent sex offenders for two reasons: (1) elsewhere there may be no mechanism for anonymous self-reports, and (2) the community may have fewer adolescent sex offender treatment programs than Hennepin County. The composition of residential treatment populations is in part a reflection of the types of alternative dispositions available to judges. Where there are many community-based programs, less serious sex offenders can be siphoned off; where there are no community-based alternatives, less serious offenders are incarcerated. Hennepin County Home School attracts those who have failed previous treatment or have been involved in more serious offenses.

Client 1

Rape (victim 3 or more years younger)	30 times
Indecent liberties (victim 3 or more years younger)	30 times
Voyeurism (dad and brother)	3 times
Incest (father/son)	10 times
(brother/brother)	15 times
(uncle/nephew/niece)	30 times

Client 4

Rape (victim 3 or more years younger)	20-30 times
Rape (victim, a peer)	6-7 times
Indecent liberties (victim 3 or more years younger)	20-30 times
Indecent liberties (victim an adult or peer)	20-30 times
Voyeurism	4 times
Exhibitionism	3 times

Client 9

Committed at least 200 rapes with young victims and at least 100 cases of incest; hit victims at least 20 times.

Client 14

Committed rape on young, peer, and adult victims; indecent liberties with youth and adults; voyeurism; exhibitionism; obscene telephone calls; and incest. He used weapons at least 5 times and hit the victim at least 10 times.

Client 26

Committed at least 123 rapes on victims 3 or more years younger; peeped, flashed, and was involved with 120 different incest offenses.

These data reaffirm what treatment providers know empirically—that the scope and seriousness of adolescent sex offenses are greater than previously acknowledged, and that Federal, State, and local officials need to take immediate steps to increase the capability and quality of

specialized service delivery both private and public, at the earliest point of recognition.

Evaluation and Assessment: A Community Safety Issue

There is increasing recognition that competent clinical assessment and evaluation, in addition to determining treatment needs, are closely bound to community safety, particularly in terms of determining which offenders get treated in the community and which do not. The criminal justice system is more consistently requiring formal psychological evaluations regarding repetition and dangerousness at various points in the judicial process. As a result, assessment and evaluation of the adolescent sex offender have become a speciality area, particularly for experienced private practitioners.

Substantial differences exist between the assessment and evaluation of the adolescent sex offender and of clients with more traditional mental health problems.[5] Within the traditional mental health profession, there is a tendency toward seriously underestimating the risks involved in evaluating and assessing the adolescent sex offender. Such errors are often made by yielding to pressure from defense lawyers, prosecutors who wish to plea bargain, other interested professionals, the offender, and his family. Dreiblatt (1982) cautions evaluators of sex offenders to remain extremely vigilant in resisting such pressures.

One major difference between assessing and evaluating adolscent sex offenders and other mental health clients lies in the type of referral questions asked. Referral questions about sex offenders usually request information on such issues as legal diagnosis, dangerousness, seriousness or

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[5]Irwin Dreiblatt of Seattle, Washington, is one of the principals in the privately owned Pacific Psychological Services. There, 150 to 200 adolescent and adult sex offenders are evaluated and/or treated each year. Dreiblatt cites six distinctive issue areas that contribute to the uniqueness and complexity of evaluating sex offenders. See Dreiblatt (1982) and Knopp (1984).

relevancy of the offending behavior, amenability to treatment and specific recommendations for case disposition. While the mental health professional is often taught to focus on why behavior has occurred, the assessment of sex offenders is more effective if there is a strong focus on what happened. This focus requires indepth and detailed personal interviewing aimed at collecting as broad a data base as possible, with as much collateral information as is available. Policy and victim reports, as well as information from family members and other social agencies, should be included. Psychological and intelligence testing and physiological monitoring of arousal patterns are means by which the examiner can broaden the data base, thus increasing the reliability of information through cross-referencing (Dreiblatt 1982).

In addition to such indepth clinical interviews, evaluation and assessment instruments should include Groth and Loredo's list of 8 key issues for the adolescent sex offender (see Knopp 1982, pp. 27-30) and the 37-point checklist of clinical risk criteria compiled by Wenet and Clark (see Knopp 1982, pp. 32-33). They also usually include some or all of the following:

Minnesota Multiphasic Personality Inventory (MMPI)
Millon Adolescent Personality Inventory
Thematic Apperception Test
Sentence completion tests
Beck Depression Scale
Draw-A-Person
Bender Gestalt Test
Rorschach
Sexual Profile and Inventory
Various intelligence and scholastic tests
Various instruments to measure family dynamics

Compared to those who work with adults, fewer evaluators of adolescent sex offenders use physiological measurements. Those who do, however, insist that for ages 14 and upward (a few measure deviant sexual arousals of youth as young as 12), assessments are more accurate and economical in terms of time consumed and range of paraphilia identified. Many practitioners do not use the penile plethysmograph, because (1) they cannot afford the technology, (2) they are not familiar with the technology, (3) reluctance exists among State youth divisions to use

this type of technology with youth in their care, and/or (4) they are not enamored of this type of assessment. This is an area where dialogue is needed between those who consider this type of assessment useful and those who are apprehensive or uninformed.

The Importance of Networking

During the last few years we have been struck by the lack of interaction among treatment providers within the same county or State and sometimes, and more surprisingly, even within the same city. Staff of many programs often are unaware of other treatment providers in their region. Whenever PREAP receives an inquiry from a blossoming treatment program, we share with them the names of all the victim, offender, and prevention programs we have identified in their State. We believe such networks should be promoted consistently and even subsidized by youth and mental health divisions. There are many benefits:

1. Networking validates an offense-specific treatment approach that is evolving into a specialized discipline.

2. Network members educate and support one another as they exchange information and treatment approaches.

3. A network identifies the professionals who comprise a ready constitutency for offense-specific training.

4. Networking provides an opportunity for standardizing the collection of data.

5. Networking produces a constituency ready to lobby for public policy change and fiscal support at the county and State levels.

6. A network has a potential for educating and furthering the concept of restoring rather than punishing adolescent sex offenders.

Networking usually includes four models: (1) an interagency approach to the adjudication and treatment of adolescent sex offenders; (2) a county approach for implementing treatment services where none exist; (3) county or statewide networks of treatment providers for adolescent sex offenders; and (4) nationwide networks that contribute to the growth and development of adolescent treatment and research for adolescent sex offenders.

An Interagency Approach

The Montgomery Center Juvenile Sex Offender Committee (Maryland), formed in July 1982 as an outgrowth of the concerns of a number of county agencies, is one example of an interagency approach. The prime mover was the Sexual Assault Service, a county-funded program of the Health Department, which had become increasingly aware of and concerned about the number of adult and minor-aged victims who had been sexually assaulted by juveniles, and about the disposition of these cases by the criminal justice system.

The committee meets monthly and includes representation from Sexual Assault Services, Child Protective Services; police departments, the Youth Division, the State's attorney's office, treatment providers, the Health Department, the Juvenile Services Administration, the juvenile court, and the Division of Children and Youth (see appendix B).

The objectives of the committee include: (1) initiating a dialogue among the agencies that serve juvenile sex offenders; (2) determining the size of the juvenile sex offender population in Montgomery County; (3) determining the dispositions of juvenile sex offense cases in the legal system; (4) assessing local treatment resources; (5) evaluating the need for additional treatment resources; and (6) stimulating the development of a countywide approach to the treatment of juvenile sex offenders.

Developing a countywide, interagency approach to the adjudication and treatment of juvenile sex offenders is an admirable and necessary goal.

A County Model for Implementing Treatment

In Bellefonte, Pennsylvania, a countywide ad hoc group representing private and public agencies has been appointed to develop comprehensive adolescent and adult treatment programs. The court and the county paid for A. Nicholas Groth, treatment specialist, to facilitate a 2-day education and training workshop on sex offender treatment. During this workshop, the court was closed so that all the judges could attend. The ad hoc group is planning a conference to lay the groundwork for implementing services.

Treatment Provider Networks

Treatment provider networks are the most common models. They have been identified in the middle Atlantic region, Minnesota, Virginia, Texas, Washington, and Oregon. The Oregon Juvenile Sexual Offender Treatment Network for Prevention of Sexual Assault is a recently formed, statewide, nonprofit organization that meets monthly, developing and sharing treatment tools and philosophies and swapping data and reading resources; it also publishes a newsletter. The network is dependent on the Lane County Juvenile Department and out-of-pocket funds. Plans include addressing both the Oregon Circuit Court Judges' Association and the Oregon Juvenile Judges and Directors.

Nationwide Networking

Since 1981, PREAP has made nationwide efforts to network treatment programs for adolescent sex offenders. In addition, the C. Henry Kempe Center has been facilitating a Network of Professionals Encountering Adolescent Perpetrators of Sexual Molestation of Children since 1983. The cooperative newsletter Interchange and the first national network meeting to focus on clinical and program considerations with adolescent perpetrators, held at the C. Henry Kempe Center on May 21, 1984, represent significant contributions to the development of treatment and research in this field. These local and national networking efforts enhance and support the idea that treatment of

adolescent sex offenders is an important and rapidly evolving discipline.

Progress in Statewide Planning

Various states, such as Delaware, Florida, New York, and Vermont, are beginning to study comprehensive statewide designs for serving the adolescent sex offender population. California provides an interesting model for bringing this issue to public attention, and the State of Washington offers the most comprehensive approach to sex offender treatment services.

Department of Youth Authority, California

California's Department of Youth Authority has identified 800 adolescent sex offenders under its care. A Youth Authority Sex Offender Task Force has 12 people assigned to study the sex offenders now under their jurisdiction and to make recommendations to Director James Rowland on treatment and public protection ideas. The group is traveling to several sites in California to hear testimony from youth authority staff and outside resource persons on these issues. This special project, directed by Sharon English, also is circulating an eight-page questionnaire (see appendix C) to all youth authority groups and programs that may be treating adolescent sex offenders, asking for their treatment theories. The goal of this exercise is to bring the issue of competent treatment for adolescent sex offenders under discussion and to validate offense-specific treatment. Two seminars on treatment of adolescent sex offenders were held in October 1984 in the southern and northern regions of the State. Over 1,000 specialists from treatment, law enforcement, the judiciary, and other professions participated.

These are highly appropriate activities for a State that has 500 committed (mostly rapists) and 300 paroled adolescent sex offenders. These figures do not count "hiddens"--those whose cases were plea bargained down from sex offenses or who are incarcerated for homicide where sexual violence was also involved.

Division of Juvenile Rehabilitation, Washington

It is fitting that Washington, the State that developed the first comprehensive program approach to treating sex offenders, has the most highly developed and sophisticated planning and data collection system and the greatest number of treatment programs. The Division of Juvenile Rehabilitation's April 1983 publication, Treatment Services for Sexual Offenders (appendix D) states its commitment to comprehensive program planning. The division's summary paper on its Violent Juvenile Sex Offender Project (appendix E) describes the need and projects plans for a residential treatment program for the most serious sex offenders.

The division sponsors six county projects in five regions to place, evaluate, and treat adjudicated adolescent sex offenders. As of November 30, 1983, the Division of Juvenile Rehabilitation's residential population of adolescent sex offenders numbered 119, or 12.8 percent of the total residential population.

Community-Based Treatment Programs

Community-based services for sexually abusive youths can be found in such diverse settings as converted houses or schools, hospital outpatient wings, mental health centers, universities, religious social service centers, and professional office buildings. New programs usually are modeled on the formats or specialties of the persons who initiated them, or they may take on the characteristics of the "regional specialty." For instance, Oregon and Washington seem to have the greatest cluster of programs with a behavioral treatment orientation, although there is only a scattering of such programs in other areas of the country. Minnesota programs have the strongest focus on positive sexuality. In the wake of A. Nicholas Groth's many training sessions nationwide, his psychosocioeducational models appear to flourish. Thus, people who do the bulk of training for adolescent sex offender treatment can influence considerably the direction of this type of therapy.

The duration of community-based treatment of adolescent sex offenders usually ranges from a low of 6 to

9 months to an average of 1 year.[6] On some occasions programs will extend beyond 1 year for certain clients. Length of treatment sometimes is equated with the number of sessions involved. For instance, individual intake and evaluation usually account for a low of 2 to a high of 6 sessions, followed by 25, 30, or up to 36 weeks of group, individual, and family therapies.

Sessions generally range from a low of 1 hour to 3 or more hours per week, plus time spent on homework and additional sessions where family therapy is involved. Clients are usually from 9 to 18 years of age, predominantly in the 14- to 17-year old range. Lately PREAP has been receiving a number of calls for referrals for programs or treatment approaches for youths as young as 7 and 8 years of age. There is a need to share information on methods of treating these extremely young sexual aggressors.

The most common components of psychosocioeducational programs used in community-based treatment are social skills training; education in human sexuality and values; victim awareness, responsibility, and empathy; anger management; sex role expectations and stereotyping; and--where clients have suffered emotional, physical, or sexual trauma--victim counseling approaches.

Most programs do not deal with drug-dependent clients. They either refer them to programs that specialize in such treatment or require that these adolescents complete or be involved in drug treatment before joining the sex offender program.

Most community-based sex offender programs use a combination of guided peer group therapy, individual therapy, and family therapy. Programs that do not include the important component of family treatment cite, as reasons for this omission, lack of staff, unavailability of parents, or inability to cope with family therapy. Generally, the treatment approach is eclectic and may combine gestalt therapy, transactional analysis, psychodrama, rational emotive therapy, and Samenow and Yochelson's identification of thinking patterns. It may also include

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[6]Where the incident was a "borderline" sexual offense, treatment may be reduced to as little as 4 weeks.

behavioral treatment employing counterconditioning methods of covert and assisted covert sensitization, reconditioning to appropriate sexual outlets, masturbatory reconditioning, and simple impulse control exercises. Methods may include intensive journal and log keeping (of fantasies, offense syndromes, or anger-evoking situations), role plays, and field trips to the scene of the sexual crime.

The Personal/Social Awareness Program (PSA), which is described in some detail in Remedial tervention in Adolescent Sex Offenses: Nine Program Descriptions (Knopp 1982, pp. 51-63), provides a unique community-based model integrating the themes of positive human sexuality and family therapy. This 8-year-old program has served over 100 families and youths. PSA resists using the label "sex offender" and instead describes its 11- to 18-year-old male and female clients[7] as those "who have violated sexual norms to the extent it is causing the family or some public agency considerable concern." The program has expanded so that it now can serve 32 families (125 clients) at one time in an intensive treatment program that usually takes 9 to 12 months to complete but may take longer.

For each client, the program includes a weekly 3-hour adolescent therapy group (two for boys and one for girls). Cotherapists lead the groups and combine peer interaction with therapist intervention. The members of the group introduce themselves in terms of their specific sexually offensive behaviors and their family situations. Group members are responsible for bringing up personal issues they need to work on and must ask for help on these issues and solicit feedback from the group. The group also addresses specific educational needs, such as male/female sexuality, venereal diseases, contraception, and so forth.

Every 2 months on a rotating basis, each group embarks on a 27-hour marathon session held overnight at a retreat center. This provides an intensive therapeutic experience governed by the same therapeutic principles as the weekly group sessions. Each client brings a list of

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[7]PSA is one of two programs in the country that have separate groups for females who are involved in sexually aggressive behaviors.

therapeutic goals that are posted on the walls and provide the basis for group evaluation that occurs at the end of the marathon. The retreat center has a pool, whirlpool, and sauna that, along with massage sessions, help participants get in touch with their bodies and senses in a positive, healthy way.

A parents' therapy group meets weekly in the evening for its own session, led by cotherapists who are also parents. The groups are governed by the same principles that guide that adolescents' groups. Parents often continue in groups even after their children leave the program.

Once every 2 weeks, the adolescent and his family meet with one of the PSA staff counselors skilled in family therapy. These meetings may be supplemented by individual therapy sessions with family members, but the family unit is the primary focus of change efforts.

Family Learning Experiences are educational events held in evening sessions once every 2 months. They provide a lecture/workshop format led by a guest expert on such topics as shame and guilt, spirituality and values, family sex education, relaxation and stress, and so forth.

The Family Journey, a weekend event held twice a year, invites all participating families to an exploration of feelings, attitudes, myths, realities, and values surrounding sexuality in our culture and in the lives of program participants. These are SAR (Sexual Attitude Reassessment) formats, and presentation topics include male/female relations, same-sex relations, masturbation, sex and aging, sexuality and handicaps, puberty, rape and sexual violence, and sex education. The journey is led by a staff of approximately 15, and sessions are evaluated by the participants.

An exit interview is conducted, and client progress is measured through a 21-item description of behaviors and attitudes ranked by the therapist on a scale from 1 to 5. Also included are staff consultations, discussions with the client and his or her family, and consultations with probation officers and social service workers. Progress is measured along a set of four overarching goals:

1. The adolescent will accept responsibility for the problem behaviors

2. The adolescent's knowledge and understanding about sexuality will be significantly improved and reduce the problem behaviors

3. The adolescent will evidence positive self-control

4. The families will provide an improved environment for the development of healthy sexuality of family members.

Groups are open to the adolescent after graduation from the program.

Forty-eight clients completed all phases of the program; of these, only 2 are reported to be recidivists. While these reported successes are impressive, this program is of interest because its emphasis is not only on sex education and values but on positive sexuality within the family context.

It is becoming increasingly apparent to me (and I have no data to validate these remarks other than my own perceptions) that because of the adolescents' stage of physiological and sexual development, an impressive number of their offenses appear to be sexual in nature but acted out through power. This is in contrast to our understanding of adult sex offense patterns, which are characterized as power and anger acted out through sexuality. I invite others' reaction to this statement.

Behavioral Treatment

At the time I wrote Remedial Intervention in Adolescent Sex Offenses, which was based on research conducted in 1981 and 1982, I was unable to locate programs using behavioral approaches with adolescent sex offenders with the exception of thought-stopping or very nonintrusive impulse control exercises. I found no adolescent programs using the penile plethysmograph, aversive conditioning, or masturbatory reconditioning. PREAP has currently identified almost two dozen programs (primarily but not exclusively in the Northwest) that use behavioral methods in combination with some of the psychosocioeducational methods mentioned previously to evaluate and/or treat

adolescent sex offenders. While in the future I hope to visit and interview program principals utilizing these methods more extensively, I report briefly now on the results of recent telephone interviews with five clinicians using behavioral methods.

Four of the clinicians use the penile plethysmograph to measure deviant arousals at intake, during treatment, and before graduation. The majority limit its use to clients at least 14 or 15 years old; however, one clinician uses physiological measurements with clients as young as 12.

A few of the clinicians use the least intrusive intervention. To decrease arousal, one clinician uses only simple thought-stopping and thought-changing exercises as a first step. If needed, he progresses to covert sensitization with aversive imagery to decrease arousal, using aversion tapes of police sirens, sounds of persons vomiting, sounds of someone being chased, and so forth. These tapes are used in conjunction with olfactory aversion (usually ammonia or placenta culture) to disrupt the arousal. Other clinicians use more intrusive behavioral methods from the very beginning of treatment; all use covert and assisted covert sensitization.

Only one of the clinicians interviewed uses electric shock with adolescents. The treatment is applied to the fingers and is described as "mild." This behaviorist recommended the combination of olfactory conditioning (using either ammonia, placenta culture, or valeric acid) and electric shock as an effective method for treating adolescent sex offenders.

All but one of the behaviorists favored increasing appropriate arousal by encouraging masturbation to age-appropriate pictures and fantasies. One clinician teaches the young people how to monitor themselves on the plethysmograph while using age- and sex-appropriate slides and tapes. Another encourages masturbation as a sexual outlet but does not encourage fantasizing to any particular theme. The clinician who does not favor using masturbatory reconditioning or satiation cites the therapist's inability to project the effects of this approach.

Oregon clinicians indicate that behavioral assessment and treatment are not frowned upon by the Children's

Services Division of that State, but other States are extremely apprehensive about using behavioral methods with children who are in community or residential custody, especially in closed settings. Issues of consent, permission, and legal liability are no doubt involved, but other factors may also influence these attitudes. Dialogue is needed between clinicians who favor behavioral treatment and those who do not. However, the controversy is a reflection of a larger problem: we lack effective tools with which to measure the benefits of various approaches and, therefore, lack the means to combine the most successful approaches into our training mechanisms.

Segregating Sex Offenders in Residential Programs

Most residential treatment programs do not provide separate cottages or quarters for sex offenders. Usually, they live in the general population but meet in separate, offense-specific groups at least once per week. A program of great interest is the 7-year-old Hennepin County Home School in Minnetonka, Minnesota. Until fall of 1982, the sex offenders were mixed in with the general population. Since that time, they have been housed separately--first, in a single cottage and, more recently, as the sex-offender population has expanded, in two cottages.

Gail Haversack, lead social worker at the school, reports considerable advantages for both staff and residents to housing sex offenders in separate cottages. Before sex offenders were separated, staff were somewhat intimidated by the offenders' manipulative and victimizing behaviors. They found that sex offenders could divide staff very successfully with issues regarding their treatment. Efforts to train staff to exercise the knowledge, confidence, and comfort needed to deal with these youngsters had to cover the entire institution. Presently, though all staff are trained to relate to the sex offender population, training is intensified in the sex offender cottages and staff are eager to become specialists.

Haversack reports that sex offenders have a far stronger treatment culture when all the residents are working on similar issues. In effect, it permits them to implement their program 24 hours a day. When all the

youngsters are dealing with their manipulative and intimidating behaviors, they can recognize them more readily in one another and help one another deal with them. Because the treatment culture is stronger and the focus can be on sexual or abusive issues all day, Haversack believes a resident's stay is shortened considerably.

Another real plus in having all the sex offenders in separate cottages is that they are more comfortable in dealing with their sexual issues; for example, they can talk more openly about homosexuality or masturbation. An atmosphere is created that allows them to receive and give nurturing to other people. They can hug one another and they can cry, which is often difficult in a generalized treatment program for adolescent males. New residents often express surprise at an older, stronger, and higher status youngster asking a peer for support and a hug. This type of modeling gives other residents permission to have their needs met in a positive way, too.

Haversack says these sex offenders put very little energy into "beating the system." For example, all the residents who have needed to have their stays extended have supported those extensions when they appeared in court. The mentality that considers the residents the "good guys" and the staff the "bad guys" is absent.

Hennepin County Home School is one of six PREAP-identified programs that will take adolescent sex offenders from out of State if they have space and if the clients fulfill certain criteria.[8]

The need for residential treatment is great. States lack the type of homelike residency that gives more structure than many families provide but not as much structure as a medium-security unit demands. In a few instances, attempts to fill this need have resulted in a small number of beds in group homes being set aside for sex offenders who then attend community-based outpatient programs for

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[8]These include the Special Care Unit, North Idaho Children's Home; the South Idaho Girls Home (adolescent female sex offenders); Nexus; the High Risk Offender Program, Lincoln Regional Center; and the Ethan Allen School. See appendix A.

sex offenders. A hopeful note is the effort being made to replicate for adolescents one of the most compelling adult treatment models identified by PREAP. A private corporate entity, Alpha Human Services, is an intensive therapeutic program for 26 adult sex offenders who reside in a homelike setting in a quiet neighborhood in Minneapolis. (see Knopp 1984). Thus far, psychologist Gerald Kaplan, Alpha's director, has not been successful in locating a suitable site for an adolescent program. Such models are sorely needed. Too many adolescent sex offenders wind up in adult maximum-security prisons where there are no services, little hope for restoration, and a high potential for sexual victimization.

A Neglected Population: The Low Functioning Sex Offender

PREAP has long been concerned about the lack of specific treatment for the low-functioning or mildly retarded adolescent sex offender.[9] Though some treatment providers include such youth among their clientele, PREAP has not found any specialized groups or tested methods for serving these clients.[10]

Most programs will not treat low-functioning or mildly retarded adolescent sex offenders. Some may include 1 or 2 in the group but admit such clients rarely get very much from the program; one program treats up to 12 such persons a year. The program we discovered with the deepest interest in, and the most data on, this clientele uses an Alcoholics Anonymous model with professional leadership, very concrete treatment, sex education, social skills training, and a support/insight focus.

Other programs report that individual treatment with occasional group work seems most helpful. These clients need a longer period of treatment, more impulse control work, more assertiveness training, and a great deal of social skills training. Everything needs to be made

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[9]IQ's usually range from high 60s through 80s.

[10]An adult residential program serving this clientele is described by Knopp (1984).

concrete. It is important to work with parents so new behaviors can be reinforced. Community networking is encouraged so neighbors can help monitor these low-functioning clients.

Everyone working with this population is hungry for information and effective treatment approaches. It is an area that requires an intensive exchange of information so that skills can be transferred to professionals who work with these needy clients.

The Need for Comprehensive Training

We are all aware of the need for training traditional mental health and other service providers in the treatment of adolescent sex offenders. Training has been carried on informally in the following ways:

1. Some treatment programs provide internships for persons who wish to learn the program's techniques.

2. Some specialists travel to various sites and conduct seminars and training sessions, usually for 1 or 2 days.

3. Special training sessions have been included in planning conferences on these issues.

4. Experienced persons serve as consultant/trainers to individuals and groups.

5. More recently, some of the local networks we mentioned earlier have been helping to keep treatment people aware of new techniques and approaches.

More formal arrangements need to be developed by Federal, State, and local agencies responsible for mental health, corrections, child sexual abuse, public health, and public safety services. Schools and departments of medicine, pediatrics, psychology, social work, nursing, and public health should include in their curricula mandated courses in human sexuality and victimology, electives in

sex offender treatment,[11] and internships in established treatment programs for sex offenders. Treatment of sex offenders should be emphasized as a recognized and valid discipline in the mental health field.

Treatment Success

Longitudinal studies of sex offenders who have completed treatment programs have not yet been undertaken; however, preliminary program results are encouraging in terms of low recidivism rates. As of spring 1985, three programs provided the following data.

The Closed Adolescent Treatment Center (CATC) in Denver, Colorado, is highly structured, secure residential program for the most serious offenders who have committed sexual and/or other violent crimes. Since 1979, CATC has released 12 sex offenders who completed the program, and none have reoffended. They have kept in touch with the program, so there has been a reasonably good check on reported reoffenses.

The second, the Hennepin County Home School in Minnetonka, Minnesota, is a low-security residential program for serious sex offenders. Of the 62 offenders who completed the Sexuality Therapy Program since 1979, only two are known to have committed a sexual offense after release. One asked to be returned to the program, and it was only after his return that staff learned what the young man had not been able to disclose previously: he had been brutally raped by his brother when he was much younger.

The Program for Healthy Adolescent Sexual Expression (PHASE) in Maplewood, Minnesota, is a community-based program serving "hands-off" and "hands-on passive" sex offenders. Among the 80 sex offenders who completed the

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[11]PREAP has identified one such university course, entitled "Sex Offender Rehabilitation" and beginning in the fall of 1984 at Nova University, Fort Lauderdale, Florida. It is to be taught be Ed Sczechowicz, Ph. D., formerly on staff at the Geraldine Boozer Sex Offender Rehabilitation Program and now in private practice.

6-month program, no subsequent offenses have been reported.

Summary

Although the incidence of adolescent sex offenses continues to be significantly underreported in official statistics, there is an increasing and discernible awareness of the extent of the problem. This is especially noticeable in the marked growth in the number of treatment services available to these clients nationwide. Many States, however, are still identified as offering only one or no such services to adolescent sex offenders.

Though treatment for adolescent sex offenders appears to be evolving rapidly into a specialized discipline, its growth is not guided by any systematic development and testing of treatment approaches and outcomes. Further, only recently developed, largely informal networks, occasional conferences, and sporadic training sessions provide the means for exchanging information and advancing treatment techniques. The magnitude of the problem of adolescent sex offenses as a public safety issue warrants more formal arrangements and fiscal commitment by Federal, State, and county agencies to both enhance and standardize research and treatment possibilities for these young clients.

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APPENDIX A

Adolescent Sex Offender Treatment
Providers, June 1985

The following State listings of individuals and agencies providing specialized services for youthful male sex offenders do not include incest programs that treat young sex offenders in the context of the incest family. One asterisk (*) indicates that treatment in groups is not provided. Two asterisks (**) denote specialized treatment provided in residential settings. All other listings represent the availability of group and other adjunctive treatment components in a community-based setting.

The Prison Research Education Action Project (PREAP) maintains nationwide files of agencies and individuals serving adolescent and adult sex offenders. Our referral capability will be enhanced if we are informed of additional adolescent sex offender treatment services not included in this listing; write to PREAP, Shoreham Depot Road, Orwell, Vermont 05760; or phone (802) 897-7541.

ALASKA

* CHILD SEXUAL ABUSE TREATMENT PROGRAM
209 Fortymile
Fairbanks, AK 99701
Wendy Warnick

ARIZONA

ADOLESCENT SEX OFFENDER TREATMENT
Youth Services Bureau, Inc.
2333 North Third St.
Phoenix, AZ 85004
Theron Weldy

** JUVENILE SEX OFFENDER PROGRAM
Adobe Mountain School
P.O. Box 35,000
Phoenix, AZ 85069
Paul S. Duda

CALIFORNIA

* PARENTS UNITED/TEENS UNITED
11519 B Ave.
Auburn, CA 95603
Sharon Sloper

** YOUTH TRAINING SCHOOL
15180 Euclid Ave.
Chino, CA 91710
Otis Brantley

** SERENDIPITY DIAGNOSTIC & TREATMENT CENTER
6441 Matheney Way
Citrus Heights, CA 95610
Robert Elliot

CHILD ABUSE PREVENTION COUNCIL
P.O. Box 2243
El Centro, CA 92243
Peggy R. Devay

JUVENILE INTERVENTION EDUCATION & PREVENTION PROGRAM
165 E. Lincoln Ave.
Escondido, CA 92028
David McWhirter

* PSYCHOLOGICAL DIAGNOSTIC & THERAPY CENTER
1523 E. Valley Pkwy.
Suite 305
Escondido, CA 92027
Raymond G. Murphy

CHILD SEXUAL ABUSE TREATMENT PROGRAM
929 Koster St.
Eureka, CA 95501
Ron Kokish

YOUTH OFFENDER GROUP
2575 Harris
Eureka, CA 95501
Mike Yeager

CHILD SEXUAL ABUSE TREATMENT PROGRAM
Family Counseling Service of Coachella Valley
82-380 Miles Ave.
Indio, CA 92201
Pat Marzicola

* AMADOR COUNSELING CENTER
P.O. Box 271
Ione, CA 95640
Gary Lowe

** OAK COUNSELING PROGRAM
Preston School of Industry
201 Waterman Rd.
Ione, CA 95640
Gary Lowe

* FAMILY SUPPORT PROGRAM
University of California at Los Angeles
Neuropsychiatric Institute C9-933
760 Westwood Plaza
Los Angeles, CA 90024
Virginia Cruz

SPARK
Children's Institute International
711 S. New Hampshire Ave.
Los Angeles, CA 90005
Bonnie Yankowitz

CHILD & FAMILY THERAPY CENTER
1210 Alhambra Ave.
Martinez, CA 94553
Donald J. Cotton

INCEST TREATMENT OF ADOLESCENT OFFENDERS
1127 13th St.
Modesto, CA 95354
Susie Winston

* SISKIYOU COUNTY MENTAL HEALTH
P.O. Box 557
Mt. Shasta, CA 96067
Arthur Silverman

** MARSHALL PROGRAM
Southern Reception Center/Clinic
13200 S. Bloomfield Ave.
Norwalk, CA 90650
Saul Neidorff

DAVID CORWIN, M.D.
11 Moraga Way #3
Orinda, CA 94563

POSITIVE INTERVENTION
1041 East Green St.
Suite 206
Pasadena, CA 91106
W. W. Robinson

FORENSIC SERVICES GROUP
718 Alhambra Blvd.
Sacramento, CA 95816
Richard Paul Mahoney

** SEX OFFENDER GROUP
Wintu Intensive Treatment Program
3001 Ramona Ave.
Sacramento, CA 95826
Rick Jeffries

GROUP THERAPY FOR ADOLESCENT SEX OFFENDERS
426 Pennsylvania Ave.
San Diego, CA 92103
Larry Corrigan

ADOLESCENT SEX OFFENDER PROGRAM
P.O. Box 952
San Jose, CA 95108
Henry Giarretto

INTERACTION
925 W. Hedding
San Jose, CA 95126
Stewart B. Nixon

** MURIEL WRIGHT RESIDENTIAL CENTER
298 Bernal Rd.
San Jose, CA 95119
Denise Glavaris

CASA DE AMPARO
4070 Mission Ave.
San Luis Rey, CA 92068
Julie Mennen

PARENTS UNITED JUVENILE OFFENDER GROUP
2400 Las Gallinas, Suite C
San Rafael, CA 94903
Cheryl Barnes

ADOLESCENT SEX OFFENDER TREATMENT GROUP
325 W. Los Olivos #C
Santa Barbara, CA 93105
Keith Mar
Kathleen Baggarley

** VALLEY COMMUNITY COUNSELING SERVICES
845 N. California Ave.
Stockton, CA 95202
David Love

* TULARE COUNTY CHILD SEXUAL ABUSE TREATMENT PROGRAM
P.O. Box 202
Tulare, CA 93275
Shirley Panitz

CHILD SEXUAL ABUSE TREATMENT PROGRAM
Mendocino County Mental Health Service
564 S. Dora
Ukiah, CA 95482
Garry Hunt

COLORADO

* ARAPAHOE COUNTY JUVENILE DIVERSION PROGRAM
15400 E. 14th PL., #329
Aurora, CO 80011
William Beene

ADOLESCENT YOUTH SEX OFFENDER PROGRAM
Moffat County Social Services
221 W. Victory Way
Craig, CO 81625
Nancy Newport

** CLOSED ADOLESCENT TREATMENT CENTER
3900 S. Carr St.
Denver, CO 80465
Vicki Agee

DARROW CLINIC
1619 Gilpin St.
Denver, CO 80218
David Becker
James Selkin
Walter Simon

** CLOSED TREATMENT UNIT
Lookout Mountain School
Golden, CO 80401
Connie Isaac
John Davis

REDIRECTING SEXUAL AGGRESSION, INC.
P.O. Box 1572
Golden, CO 80402
Connie Isaac
John Davis

** BLUE SPRUCE TREATMENT UNIT
Lookout Mountain School
Golden, CO 80401
Tom Leversee
Susan Law

ADOLESCENT BOYS GROUP
Arapahoe County D.S.S.
5334 S. Prince
Littleton, CO 80166
Judith Powers-Smith

* ARAPAHOE COUNTY JUVENILE DIVERSION
5804 S. Datura
Littleton, CO 80120
Jenni King

CONNECTICUT

FORENSIC MENTAL HEALTH SERVICE OF CONNECTICUT
New London Exchange B
190 Governor Winthrop Blvd.
New London, CT 06320
Peter Loss
Jonathan Ross

DELAWARE

ADOLESCENT PERPETRATORS GROUP/PARENTS UNITED
124D Senatorial Dr.
Greenville PL
Wilmington, DE 19807
Joanne M. Kassees

DISTRICT OF COLUMBIA

JUVENILE ABUSER TREATMENT PROGRAM
Children's Hospital
111 Michigan Ave. N.W.
Washington, DC 20010
Paul Mitchell

FLORIDA

* BROWARD COUNTY SEXUAL ASSAULT TREATMENT CENTER

1526 S. Andrews Ave.
Ft. Lauderdale, FL 33316
Joanne G. Richter

S. FLORIDA ADOLESCENT OFFENDER PROGRAM
Westland Professional Bldg., #492
1490 W. 49th PL
Hialeah, FL 33012
Edward S. Sczechowicz

** YOUTHFUL SEX OFFENDER PROGRAM
1000 S.W. 84th Ave.
Hollywood, FL 33025
Edward S. Schzechowicz

ADOLESCENT SEX OFFENDERS PROJECT
Advocate Programs, Inc.
1500 N.W. 12th Ave., #702
Miami, FL 33136
Robert A. Ameo

S.T.O.P.
A & A Professional Counseling Association
7241 S.W. 63rd Ave., #200
Miami, FL 33143
William R. Samek

BAY COUNTY GUIDANCE CLINIC
615 N. MacArthur Blvd.
Panama City, FL
Dan Kiczerow

GEORGIA

CHILD & FAMILY COUNSELING CENTER
114 Hospital Dr.
Warner Robins, GA 31093
Mary Doby

HAWAII

* JACK S. ANNON, PH.D.
1380 Lusitana St., #909
Hoonolulu, HI 96813

* SEXUAL IDENTITY CENTER
P.O. Box 3224
Honolulu, HI 96801
David Bohn

IDAHO

KOOTENAI TREATMENT ASSOCIATES
2110 Ironwood Pkwy., #208
Coeur d'Alene, ID 83814
John Farley

REGION II MENTAL HEALTH SERVICES
1118 F St.
Lewiston, ID 83501
Steve Lindsley

** SPECIAL CARE UNIT
N. Idaho Children's Home
P.O. Box 319
Lewiston, ID 83501
Mark Hopper

* DEPT. OF HEALTH & WELFARE
P.O. Box 749
McCall, ID 83638
Sandra Strange

S.A.N.E.
Community Health Center
1504 3rd St., N.
Nampa, ID 83651
Pam Bekkedahl Seiders

COMMUNITY TASK FORCE AGAINST CHILD SEXUAL ABUSE
c/o Daughters & Sons United
P.O. Box 4193
Pocatello, ID 83201
Walter D. Haworth, Jr.

** S. IDAHO GIRLS HOME
Box 4669
Pocatello, ID 83201
Jeannette Grimmette

* IDAHO YOUTH SERVICES CENTER
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APPENDIX B

Identifying Adolescent Sex Offenders:
Family Incest Treatment Programs as Source

(A PREAP Survey, May 1, 1984)
Susan Thompson

Summary

The purpose of this survey was to identify the number and types of treatment programs for adolescent sex offenders that evolved as a result of treating the incest family. Twenty-six programs responded positively to the survey. They reported the following:

- 88.4 percent stated that awareness of the need for a treatment program for adolescent sex offenders emerged as a result of treating the incest family
- 100 percent offer outpatient treatment (15.3 percent also have a residential component)
- 92.3 percent provide group treatment; the majority have three to eight participants and meet once a week for 90 minutes
- 34.6 percent provide treatment to female adolescents
- 19.2 percent provide treatment to developmentally disabled adolescents
- 92 percent treat child molesters; 73 percent treat exhibitionists and voyeurs; 46.1 percent treat rapists
- 13 programs have no project descriptions; 12 do not collect program data

Survey Method and Purpose

On December 20, 1983, surveys (see attachment 1) were mailed to a list of 99 Child Sexual Abuse Treatment Programs in 29 States (see attachment 2).[1] The purpose of this survey was to identify the number and types of treatment programs for adolescent sex offenders that evolved as a result of treating the incestuous family.

Results

Of the 99 surveys mailed, three (3 percent) were returned (wrong address/nondeliverable); 57 (57.5 percent) responses were received. Of these 57 responses, 31 (54.3 percent) indicated they had no adolescent sex offender treatment program. However, three (5.2 percent) of these programs stated they were currently developing such programs. A fourth program was considering development of such a program. Two additional programs stated they recognized the need for adolescent sex offender treatment. Another reported they "are seeing some cases but not enough to warrant a program." One other program said the "problem [adolescent sex offenses] has begun to manifest itself."

Of the 57 respondents, 26 (45.6 percent) indicated they have services in their program for adolescent sex offenders. All 26 programs offer outpatient treatment for adolescent sex offenders. Of these 26 programs, four (15.3 percent) have a residential component for adolescent sex offenders (though these residential centers are not exclusively for adolescent sex offenders). None of these residential programs accept out-of-state referrals. Eleven (42.3 percent) of the 26 programs also treat adult sex offenders; one of these programs has an adult group in the local jail. One program did not respond to this section.

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[1] This listing of Child Sexual Abuse Treatment Programs and Parents United chapters was provided to PREAP by the Institute for the Community as Extended Family, P.O. Box 952, San Jose, California 95108.

Of the 26 programs treating adolescent sex offenders, 23 (88.4 percent) stated that awareness of the need for a treatment program for adolescent sex offenders emerged as a result of treating the incest family.

Specific Findings

Group Treatment

Of the 26 programs, 24 (92.3 percent) offer group treatment to adolescent sex offenders. The 2 other programs stated that they saw the need for groups but currently did not have a sufficient number of clients. Twenty (76.9 percent) of the 26 programs also provide individual (one-to-one) treatment for adolescents. Six progams (23 percent) stated they also offer family treatment for adolescent sex offenders.

Number in each group. Of the 24 programs offering group treatment, the majority service three to eight adolescents in each group. The lowest reported number in a group was two (reported by one program); the largest number of participants was 15 (reported by one program). The modal group numbers were four, five, and eight (three programs each). Two programs did not respond to this question.

Age range of participants. The age range of participants in treatment for adolescent group sex offenders was from 11 to 21. The majority of adolescents in these groups were between the ages of 12 and 18. Ten programs did not respond to this question.

Length and frequency of meetings. Only 15 programs reported the length of time involved in group treatment of adolescent sex offenders. Of these 9 meet for 90 minutes; 2 meet for 2 hours, plus an additional hour in a group with the participants' parents; 2 other programs meet for 2 hours; and 2 programs reported their groups meet for 1 hour.

Eighteen programs reported that their groups meet weekly. Only one program stated that their group meets

every other week. Seven programs did not respond to this question.

Criteria for group participation. Of the 24 programs that offer group treatment for adolescent sex offenders, 17 (70.8 percent) listed at least one criterion for participation. Six stated the participant must be a male adolescent. Four programs reported they would treat only nonviolent sex offenders or persons with no history of physical violence. Two programs stated that the group participant must be known to the court or to children's protective services. One program stated they treat only first-time offenders. Another program reported they treat only adolescents who had committed abuse within the family. One program stated that their criteria for group participation included individual treatment as well as involvement in family therapy. Seven programs listed no criteria.

Female Adolescent Sex Offender Treatment

Of the 26 programs that provide treatment for adolescent male sex offenders, 8 (30.7 percent) also provide services for female adolescent sex offenders. Eighteen programs (69.2 percent) stated they do not treat female adolescent sex offenders. However, 2 of these programs reported they were not presently treating female adolescent sex offenders because of the limited number of these clients. Another program stated they had previously treated females with male adolescents in group treatment but currently had no females in treatment.

Treatment for the Mentally Retarded and Developmentally Disabled Adolescent Sex Offenders

Of the 26 programs treating adolescent sex offenders, 4 (15.3 percent) reported they treat mentally retarded or developmentally disabled adolescent sex offenders. Only 1 respondent specified that they treat the developmentally disabled. Twenty (76.9 percent) stated they do not treat this category of offender. However, 3 programs stated they would treat such persons if they received referrals. One of these programs stated that they would probably

have a separate group or program for such individuals when they received referrals. Another program, not presently treating this category of offender, stated that they do serve a developmentally disabled population in a prevention program. Two programs did not respond to this question.

Categories of Sex Offenders Treated

Of the 26 programs, 19 (73.0 percent) stated they treat the "less serious" (exhibitionist, voyeur) adolescent sex offender. Five programs (19.2 percent) reported they do not treat this category of offender.

Twenty-four (92.3 percent) of the 26 programs reported they treat the "more serious" (molester) offender.

Of the 26 programs, 12 (46.1 percent) stated they also treat the "most serious" (rapist) sex offender. Two other programs reported they would treat the most serious sex offenders conditionally. Ten programs (38.4 percent) stated they would not treat this category of sex offender. Two programs did not indicate the categories of offenders they treat.

Program Descriptions and Data Collection

Of the 26 programs treating adolescent sex offenders, 5 sent descriptions of their projects. One program stated their description was undergoing revision; another program reported their description was not specific to juvenile offenders. Thirteen programs (50.0 percent) reported they did not have descriptions of their projects. Eight programs did not respond to this section.

Three of the 26 programs stated they collect data on their programs. Another 5 reported they would have data in the future. Four programs stated their programs were too new for any data to be compiled. Twelve programs stated they had no program data. Three programs did not respond to this section.

ATTACHMENT 1

Dear Friends;

PREAP maintains a nationwide file of programs that treat adolescent and adult sex offenders and victims of sexual abuse. We are in the process of updating our files on treatment programs for adolescent and adult sex offenders. We are particularly interested in adolescent treatment programs that have emerged from programs treating sexually abused children and their families.

Would you please respond to the following questions:

1. Do you have a program for adolescent sex offenders? _____

2. Title of program _____
   Address _____
   Phone _____ Contact person _____

3. Type of program: Adolescent _____
   Adult _____ Outpatient _____
   Residential _____ Group _____
   One-to-one _____ Other _____

4. Did the need for a program for adolescent sex offenders emerge as a result of treating the incest family? Yes ___ No___
   Comments:

5. If group program, briefly describe: Number in each group _____;
   age of participants _____;
   frequency/length of meetings _____
   _____; and special criteria for group participation:_____
   _____
   _____

6. Do you have a program for female adolescent sex offenders? _____
   If this program differs from the male adolescent sex offender program, please describe:

7. Does your program service developmentally disabled or mentally retarded sex offenders? _____ Please describe if this is a separate program component:

8. If this is a residential program, do you accept out-of-state adolescent sex offenders? _____
Do you have criteria for acceptance? _____
Please list:

9. Please indicate which category of sex offender you treat in your adolescent program:
   a. Less serious (exhibitionist, voyeur)
   _____
   b. More serious (molestation)
   _____
   c. Most serious (rapist) [penetration]
   _____

10. Is there a project description available?_____
(Please enclose)

11. Are program data available on age, type of offense, history of offenses, and recidivist rate? _____ If yes, could you please enclose?

Thank you for your assistance. For your convenience, we have enclosed a self-addressed envelope.

Sincerely,

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ATTACHMENT 2

Child Sexual Abuse Treatment Programs and Parents United Chapters

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This listing of Child Sexual Abuse Treatment Programs and Parents United chapters was provided to PREAP by the Institute for the Community as Extended Family, P.O. Box 952, San Jose, California 95108.

APPENDIX C

Department of the Youth Authority
Sexual Offender Task Force

Format for Submission of Written/Verbal Information

Scope and Nature of Problem

1. How do you define "sex offender"?

2. What types of sex offenders are you encountering?

3. What do we need to know about sex offenders? Age at first offense, done in concert or alone, etc.?

4. How many have sex offenses in their background but not as a committing (or adjudicated) offense?

5. How many were victims themselves (physical or sexual abuse, neglect) and was the history of abuse documented?

6. How do you account for the dramatic increase in the incidence of sex offenses?

7. Are there significant cultural factors to be considered?

8. Have you experienced situations where families have encouraged deviant sexual behavior (i.e., incest, bestiality, prostitution, pornography)?

Treatment Services

1. What major components should be present in a model sex offender treatment program? Is there an optimal length of time for the institutional phase?

2. Upon what literature/theory is your program or approach based? Provide indicators of effectiveness.

3. Does the youth authority need more programs and/or services specifically for sex offenders?

4. What community resources do you utilize? Which are most effective? What is a good measure of effectiveness?

5. What needed community resources are not available? Residential care and supervision, therapy, etc.?

6. What kinds of aftercare services and followup are needed?

7. What types of coordination between institutional and parole and/or community services are needed?

Surveillance and Control

1. Are some sex offenders, in your opinion, not treatable? Which are the most difficult to treat?

2. Should they be segregated and otherwise controlled in the institutional setting?

3. Can sex offenders be profiled by their patterns of victimization and/or their method of operation? Please describe.

4. Should juvenile sex offenders be required to register?

5. Following discharge from parole, what surveillance/control measures are available (i.e., notification of law enforcement)?

6. What other criteria or factors to minimize risk should be considered?

Training

1. What type of training have you had in this area? Who provided it? Was it effective?

2. What additional training resources are needed? Where are they located?

Victims

1. How can the youth authority work with victims of sex offenders?

2. What kinds of victim-offender reconciliation activities are realistic and appropriate for the youth authority?

Developed by California Department of Youth Authority, 1984. For further information, contact:

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4241 Williamsbourgh Drive
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APPENDIX D

Treatment Services for Sexual Offenders
Division of Juvenile Rehabilitation

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
WASHINGTON STATE

April 1, 1983

Contact Person: Judy Ramseyer
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SCAN 234-7598

Introduction

The foundation of treatment programming for youth committed to a term of confinement within the Division of Juvenile Rehabilitation is the residential facilities operated by, or under contract with, the division. All of these programs are conducted on a behavioral modification model that emphasizes the learning of responsible daily living skills. Each juvenile offender is assigned a counselor who develops an individual treatment plan for that person. This counselor is responsible for guiding the treatment process for the youth. These responsibilities include providing individual counseling and other counseling opportunities as necessary, school and/or work programming, discipline and daily youth supervision, interaction with collateral resources for the youth, and maintenance of the procedural standards and reports required by the agency.

All of these programs, institutional and community based, work to help juvenile offenders gain skills to manage their lives more effectively without resorting to criminal or destructive behavior. Interpersonal and social skills, anger management, substance abuse programs, academic and work skills, and many other specific skill building

activities comprise the total milieu of each of these residential programs that house juvenile offenders during their term of confinement. (See Table D-1.)

Sex Offender Model

The juvenile sexual offender enters this milieu upon commitment to DJR. All of the programs and resources available to any juvenile offender are available to the sexual offender. In addition, separate standards apply for the youth charged with a current or prior sex offense that dictate that the sex offender receive treatment services that directly address the offense behavior. These standards are in place throughout the agency so that any sex offender, regardless of placement or length of sentence, is receiving offense-specific case management.

This model states that all sex offenders must be identified and receive a diagnostic evaluation that addresses factors characteristic of the sexual offender. All reports must document treatment goals related to that offense and specific strategies being used to pursue those goals. All interventions should be designed to move the offender toward broad treatment goals, specifically defined by the individual case. These broad goals are:

1. increased responsibility for one's sexual behavior;

2. increased awareness of the impact of sexual abuse on the victim;

3. increased understanding of the emotional and psychological processes that led to the offense; and

4. increased skill in meeting one's sexual and interpersonal needs without victimizing others.

Significant program decisions should reflect consideration of the youth's investment and progress in the treatment process. If progress is minimal, supervision should continue as it would for a high-risk offender.

Table D-1. Sex offenders in DJR residential population (February 28, 1983): Distribution of offense/institution

Institution	Rape 1	Rape 2	Rape 3	Statutory rape 1	Statutory rape 2	Indecent liberties	Incest	TOTAL	Percent of residential population
Echo Glen **R = 184	4	2	1	9	0	44	0	60	32.6
Maple Lane R = 145	3	2	1	4	0	21	1	32	22.0
Green Hill R = 141	5	0	0	0	0	4	0	9	6.4
Mission Creek R = 62	0	0	0	0	0	1	0	1	1.6
Naselle R = 92	0	0	0	0	0	2	0	2	2.2
DJR Group Homes R = 106	2	1	0	0	0	2	0	5	4.7
CRPs R = 199	2	3	0	1	0	4	0	10	5.0
	16	8	2	14	0	78	1	119	12.8% of of total DJR residential population
Percent of sex offender population (119)	13.4	6.7	1.7	11.8	0	65.5	0.8		

Note: Total residential population = 929
Youth committed for sex offenses* = 119 (12.8% of DJR residential population)

* Does not include prior adjudication for sex offenses
** R = residential population of facility

Extensive training has been offered to staff in all DJR programs to provide them with the basic information needed to comply with these standards. Ongoing training and case consultation are available throughout the agency. A program manager in DJR's Central Office has primary responsibility to direct the development and monitoring of these services throughout the agency.

Institution Services

Three major institutions--Green Hill School, Maple Lane School, and Echo Glen Children's Center--and two youth forestry camps--Naselle Youth Camp and Mission Creek Youth Camp--are the institutional facilities operated by DJR. Case managers in each of these facilities should be providing individualized treatment plans that specifically address the offense behavior for any sex offender on their caseload. Specialists are available for case consultation and evaluation purposes. Green Hill School, Maple Lane School, Echo Glen Children's Center, and Naselle Youth Camp each have one staff person designated to oversee and coordinate treatment services for sex offenders on that campus. (See Table D-2.)

A wider variety of treatment services for sex offenders is available at Maple Lane School and Echo Glen Children's Center. Sex offenders committed to DJR tend to be concentrated at one of these institutions. Therapy groups for sex offenders are offered, as well as the individual counseling provided to all. Specialists are readily available for consultation. Private therapists in the community are used for youth on an outpatient basis if this is felt to be necessary. Family counseling is encouraged if the offender's family is at all receptive to this. A variety of education experiences is available to the sex offender, such as sex education, assertiveness training, anger management, drug and alcohol management, and so on. These special services augment the daily milieu program, which is also designed to confront issues directly related to the offense behavior.

Table D-2. Various services available for sex offenders

Services for sex offenders	Green Hill School	Maple Lane School	Echo Glen Child. Center	Naselle Youth Camp	Miss. Creek Youth Camp	Cascade Program	Wash. Prog.
1. Offense-specific diagnostic evaluation			X				
2. Offense-specific individual counseling	X	X	X	X	X	X	X
3. Offense-specific group counseling		X	X				
4. Offense-specific family counseling			X				
5. Specialist available for case consultation & technical assistance	X	X	X	X	X	X	X
6. Private specialist available for outpatient therapy		X	X				
7. Sex education	X	X	X				
8. Specific skill building activities (anger management, assertiveness training, drug/alcohol management, etc.)	X	X	X	X	X	X	X
9. University of Washington Juvenile Sexual Offender Program			X			X	X
10. Sex Offender Project through county juvenile court							

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Table D-2. continued

Services for sex offenders	Reg. 1 Gr. Home/ Cmty. Sup.	Reg. 2 Gr. Home/ Cmty. Sup.	Reg. 3 Gr. Home/ Cmty. Sup.	Reg. 4 Gr. Home/ Cmty. Sup.	Reg. 5 Gr. Home/ Cmty. Sup.	Reg. 6 Gr. Home/ Cmty. Sup.
1. Offense-specific diagnostic evaluation	X	X	X	X	X	X
2. Offense-specific individual counseling	X	X	X	X	X	X
3. Offense-specific group counseling						
4. Offense-specific family counseling						
5. Specialist available for case consultation & technical assistance	X	X	X	X	X	X
6. Private specialist available for outpatient therapy	X	X	X	X	X	X
7. Sex education						
8. Specific skill building activities (anger management, assertiveness training, drug/alcohol management, etc.)	X	X	X	X	X	X
9. University of Washington Juvenile Sexual Offender Program				X		
10. Sex Offender Project through county juvenile court		X	X		X	

Community Services

It is fully expected that offense-specific services for the sex offender will be extended through placement in a community facility and supervision on parole status. The extent to which these specialized services are provided is dependent on the skill level of individual counselors and the availability of community resources for the juvenile sex offender. It is not unlikely for offense-specific services to intensify when a sex offender enters the community, especially if that youth comes from an institution with fewer specialized services or is felt to be at high risk to reoffend.

The Juvenile Sexual Offender Program at the University of Washington is available to staff and youth throughout the division but, realistically, is most often used by those located in King County. The Juvenile Sexual Offender Program offers evaluations, family therapy, and a group for DJR youth on residential or parole status. King County (Region 4) also contracts with other community specialists who provide treatment for sex offenders. Spokane (Region 1), Benton-Franklin (Region 2), Snohomish (Region 3), and Pierce (Region 5) counties also have private therapists available to provide treatment for juvenile sex offenders under contractual agreements.

Snohomish and Benton-Franklin counties both operate Juvenile Sex Offender Projects through the juvenile court. These two programs differ in some ways, but each provides the same basic services:

1. knowledgeable and consistent evaluation and prosecution of sex offenders;

2. alternatives to institutionalization for the low- to moderate-risk sex offender that consist of various combinations of detention, supervision, and treatment; and

3. a structure for the extension of responsible supervision and treatment of the sex offender upon release from a term of confinement.

The development of these projects has required the cooperation of law enforcement, legal, social service, and therapy professionals in the community who recognize the

need for just and responsible disposition of juvenile sex offenders. These projects represent an excellent example of local network development around a special need.

Conclusion

What has been described here is not a discrete program for juvenile sex offenders, but instead an accountability model that directs the delivery of specialized services for the sex offender, designed to reduce that offender's risk to the community. There are no guarantees that treatment will be exhaustive and complete. Each case is entirely unique. One youth may make a great deal of progress in a short period of time, presenting a considerably reduced risk to the community upon release. A second youth may make little or no progress over a very long period of time, being discharged from DJR supervision as great a risk to the community as when originally submitted. It is DJR's responsibility to use the time a youth is in our custody as productively as possible to facilitate the juvenile offender's successful return to the community. Specialized services for the sexual offender increase the possibility that critical factors contributing to the offense behavior will be addressed, reducing that offender's risk of reoffending sexually in the future.

Community Corrections Program Model for Juvenile Sex Offenders

Purpose

It is essential that the Division of Juvenile Rehabilitation take a leadership role in the creation of juvenile justice networks throughout the State of Washington. A combination of State, county, Federal, and private funds enables a more comprehensive array of program services to develop than a single funding source could produce. The concept of community corrections is designed to facilitate the creation of these networks, tailored by local needs to meet statewide objectives. The goals of community corrections programs as set forth in the Community Corrections Program Standards are to:

1. coordinate program strategies based on identified juvenile offender needs that promote just handling of the juvenile offender at the community level;

2. develop comprehensive community plans for the delivery of services to juvenile offenders via broad-based professional/citizen input;

3. encourage development of a unified system among State and local resources; and

4. set forth a clear administrative structure that ensures monitoring and evaluation of the delivery system.

A program that focuses on the special needs of the juvenile sexual offender is highly compatible with these goals. Juvenile sexual offenders are often identified as different from the average delinquent population. A lack of extensive criminal history and emotional immaturity are common. Society has tended to view sex offense behavior as "sick" as well as criminal, therefore warranting therapeutic treatment. The Juvenile Sexual Offender Program at the University of Washington, the first nationally recognized program to address specifically the needs of the juvenile sex offender, maintains that sex offense behavior by a juvenile is indicative of problems in the family system. Based on their research to date, it is proposed that the most effective strategy for treating these offenders is within the context of the family. A community corrections model provides the opportunity to work within the family system while fulfilling the legislative mandate for juvenile justice.

Community protection can be achieved through the use of varying levels of structured supervision. All resource people become participants in this network for supervision. The family, the probation/parole counselor, schools, employers, therapists, and so on all provide structure and supervision for these youth. Such a model encourages the development and collaboration of local resources. Each community must define its own capacity for serving these youth. Criteria for offender eligibility and the development of service networks will vary accordingly.

A community corrections program for juvenile sexual offenders can be a cost-effective use of State and local resources. Population in State-operated juvenile institutions is over capacity, and this trend is expected to continue. If it is possible to supervise and treat certain sexual offenders effectively in a less restrictive and less expensive setting, this should be encouraged. Institutional programs are better used for those offenders who present a clear risk to the community. If, as postulated, treatment of the whole system in which the youth lives is the most effective therapeutic intervention, the benefits to local communities of reducing victimization and the resulting trauma cannot be estimated.

This model outlines the basic framework of a community corrections program for the juvenile sexual offender. For demonstration purposes, specific examples from the current Snohomish County Community Corrections Program have been used to define eligibility criteria and supervision requirements. Each county must modify and enlarge this basic framework to fit its own unique characteristics.

Program Description

I. Program development

- A. Identify community need
- B. Define network of services providers
- C. Train service providers
  1. DJR training and technical assistance
  2. Local experts
  3. Shared expertise between communities

II. Assessment

- A. Standardized pre-dispositional evaluation
  1. Performed by person(s) who understand criteria and intent of program
  2. Recommendations regarding disposition

B. Criteria for eligibility
   1. Minor or middle offender
   2. Nonviolent offense
   3. No criminal history of sexual offenses
   4. No previous treatment for sexual offenses
   5. Family of offender willing to participate in treatment

III. Supervision

A. Mandated activities
   1. Probation/parole counselor contact at least three times weekly
   2. 20 to 30 days in detention to be served on weekends following the disposition hearing (10 to 15 weekends)
   3. At least 72 hours of community service to be worked 8 hours per weekend (1 day) following completion of detention time
   4. Court-ordered to maintain a combination of the following activities totaling 40 hours per week of incapacitation*
      a. regular school attendence
      b. alternative school attendance
      c. Youth Resource Center attendance
      d. full-time employment
      e. part-time employment
      f. counseling
      g. drug/alcohol treatment
      h. other organized and structured activities as ordered
   5. An alternative community program that provides comparable incapacitation to item 2 above (e.g., The Washington Program, Outward Bound)

B. Degree of incapacitation
   1. At least 40 hours of organized and monitored activities each week
   2. 2-1/2 to 4 months of complete incapacitation on weekends

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*Incapacitation defined as organized structured activity in which a youth's attendance can be monitored.

3. At least 2 months of partial incapacitation on weekends
4. Ability to detain additionally if necessary

C. Postinstitution supervision of sexual offenders
1. Probation/parole counselor contact at least three times weekly
2. Maintain a combination of the activities listed in II.4.a-h, totaling 40 hours per week of incapacitation

D. Monitoring/evaluation
1. Probation/parole counselor responsible for regular contact with collateral agencies
2. Degree of incapacitation can be amended based on ongoing evaluation of offender's performance in all areas

IV. Treatment

A. Offense-specific treatment by qualified therapist(s) required

B. Family participation in one or more of the following:
1. Therapy with the offender
2. Remedial programs:
   a. parenting skills
   b. individual counseling
   c. alcohol/drug treatment
3. Provision of supervision and structure for the offender

C. Probation/parole counselor responsible for regular contact with therapist(s)
1. Degree of offender's incapacitation can be amended based on treatment progress

D. Offense-specific treatment mandated activity for postinstitution parolee

V. Monitoring and evaluation

A. Community network of service providers
1. Monthly information-sharing meetings
2. Contact as required for client supervision

B. Training and consultation
   1. General topic areas
   2. Specialized topic areas
   3. Policies and procedures

C. Program review and evaluation

Conclusion

A community-based program designed for juvenile sexual offenders truly embodies the concept of community corrections. Local communities can design a program that defines criteria for offender eligibility and degree of supervision/incapacitation based on the resources available to them. It requires a desire to respond to the needs of the juvenile sexual offender and the belief that local agencies can work cooperatively. It is the responsibility of the DJR to identify this program as a priority and include it in each regional request for services. Technical assistance in program development and ongoing training must also be offered by the division. The ideal opportunity exists to offer a viable alternative to institutionalization that is compatible with the characteristics of the juvenile sexual offender and the goals of community corrections. The Division of Juvenile Rehabilitation has a commitment to improve services for this special offender group. DJR must extend this commitment by promoting the development of community corrections programs for the juvenile sexual offender.

APPENDIX E

Summary Paper:
Violent Juvenile Sex Offender Project

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Need Statement

The Division of Juvenile Rehabilitation has made significant progress over the last few years in addressing the needs of the adolescent sex offender. However, the strongest emphasis to date has been on treatment interventions for the relatively less aggressive offender. By contrast, the violent juvenile sex offender has received far less attention in terms of innovative program development.

The majority of institutionally based treatment resources for our sex offenders are concentrated at Echo Glen and Maple Lane School. However, the most violent of our sex offenders are often sent to Green Hill School. This is particularly true when the youth is older and more involved in other delinquent behaviors; Green Hill's overall program is better equipped to meet the needs of the more "delinquently sophisticated" youth.

Statistics recently compiled from Green Hill reveal that there are 12 youths currently in residence for a sex offense and that nearly half of these are under sentence for the most serious sex crime possible--rape in the first degree. (This number is thought to be an underreport, as it does not contain crimes charged with other titles when the motive is clearly sexual, such as certain assaults and kidnappings.) These same statistics also show that we have these youths in our system for long sentences: the average sentence range of the sex offenders presently at Green Hill is 2-1/2 to 3 years.

Simply put, this is our situation: our most dangerous sex offenders generally are sent to Green Hill for long

sentences, yet there are fewer treatment resources at this facility for sex offenders than at other major institutions.

Project Intent

It is this project's intent to provide intensive offense-specific treatment for violent juvenile sex offenders who are under court commitment. The program model would use a variety of interventions featuring "state-of-the-art" approaches. It would build on the sex offender expertise extant within the DJR. It would incorporate additional techniques and technologies that have demonstrated effectiveness at Western State Hospital, Northwest Treatment Associates, and the Closed Adolescent Treatment Program in Denver. Because of the factors cited above, Green Hill School is seen as a logical location for this project.

The primary long-term goal is to reduce recidivism. To document this and to learn which specific interventions are most effective, a significant evaluation component will be built in. It will be a short-range objective to provide treatment in a secure setting to 14 youths during the first project year. It will be an objective to provide for effective community protection during the entire time of the youth's involvement in the project. Finally, an additional first-year objective includes development of staff expertise in treatment of the violent juvenile sex offender.

This project would target for its population youth at least 16 years of age who have received a minimum sentence of 1 year when the committing delinquency was a sex offense or when motives of sexual aggression were present. Assignment would be made based on the seriousness of the youth's behavior, with those youths whose behavior shows a pattern of escalation and risk of recidivism being given the highest priority. It is the intent of this project to take as many such youths as possible without overcrowding the facility.

Project Implementation

The project is conceived as a residential treatment model with three phases. The first and most treatment-intensive phase would occur on the institutional grounds. The second phase would occur during the period of group home placement within the community. The third phase would occur during parole supervision.

Phase One would be the longest; the exact length of stay would depend on the individual youth's progress, division policies pertaining to security levels, and perceived risk to the community. It is anticipated that most youths would serve at least the first two-thirds of their sentence within the institution. This phase would immerse the youth in offense-specific treatment within a secure, structured setting. One specific cottage with the capacity for maximum security would house all project youths (and only these youths) during Phase One.

Phase Two placement would occur in any one of a number of State group homes or CRPs. The goal of this phase would be to deal with transition and community reentry issues while building a network of services for the youth (and for his family or release placement). This network would include appropriate clinical counseling services, educational/vocational resources, and a relationship to Juvenile Parole Services. Ideally, Phase Two placement would be in or accessible to the locale of the youth's intended release placement. At present, various communities throughout the State are involved in efforts to develop their own locally based programs for juvenile sex offenders. Such communities would provide a natural environment for developing these networks. Thus, flexibility in placement possibilities during the reentry phase would exist.

Phase Three of the program would occur during a period of intensive parole supervision. Project youths would automatically be placed under such supervision for at least 1 year. Continuation in treatment would be a universal condition of parole. Emphasis on the use of the community network would be stressed. The foundation of the provision of services for the youth, his family, and often for his victim as well (i.e., when the victim was a family member) will have been laid during the Phase Two

stage, so that the movement to parole status will be a smooth transition.

Phase One Components

Accurate assessment of specific treatment needs for each youth will occur. A psychological evaluation will be conducted on any youth who has not had this done prior to commitment. Sex offense-specific evaluation will be completed for all youths following DJR guidelines currently in place. In addition, the DJR tool, Inventory of Sexual Aggression, will be administered.

Each project youth will be screened at entry via plethysmograph testing. This technology measures the presence of deviant arousal patterns, such as pedophilia and arousal to themes of aggression. It is postulated that the population of youths in our project will be more likely to exhibit such deviant patterns. A local treatment program (Northwest Treatment Associates) that specializes in adult sex offenders states that plethysmograph testing reveals deviance in the vast majority of their clients, and that most of these men began their patterns in adolescence. By determining the specific nature of such patterns when they exist, an individualized behavior modification program can be constructed.

Reoffense risk will be assessed and documented at entry. The Decision/Risk Criteria tool developed by the University of Washington will be used in that process.

Each youth will be involved in a minimum of 21 hours of group therapy per week. There will be much emphasis on the development of a pro-treatment group norm. Approximately 15 hours a week will be spent in group sessions using an adapted version of the WSH model (this uses much structure and incorporates sharing of offense and sexual/masturbatory fantasy details, among other topics). The remaining 6 hours per week will be spent in skill-building group work. Video equipment will be used here, giving the youth a clear "picture" of how his new skills look in action.

One-to-one therapy will also occur; the focus will be individualized. Youths who have demonstrated deviant

arousal patterns will receive treatment, such as covert sensitization and masturbatory satiation.

All other resources of the institutional program (e.g., vocational, educational, recreational) will be available to the youths, based on security level consideration.

The youths' investment and progress in treatment will be a criterion in deciding movement from Phase One to Phase Two; this is to assure the DJR's accountability to community safety issues. Determination of progress will be done as objectively as possible. This will always involve reevaluation of risk factors and may often include change as measured via plethysmograph retesting.

Staffing and Roles

The Phase One cottage will follow the standard cottage staffing pattern, with the addition of one JRC II position. This additional staff member will allow for a higher staff/youth ratio, which is seen as necessary in such an intensive program. Reallocation of current staff could account for all but that one position. The staffing pattern would be:

1 JRS III (Program director)
8 JRC IIs
2.4 JRC Is
11.4 Total staff

The Program Director would work closely with the Division's Sex Offender Specialist in implementing and monitoring the project. The Sex Offender Specialist would also assist in team building, staff training, and consultation and will facilitate project evaluation and program component research.

Training and Consultation

A strong emphasis will be placed on initial and ongoing staff training. Use will be made of existing resources in the DJR and State system (including use of the Sex Offender Specialist as cited earlier). The Adolescent Clinic

at the University of Washington will also be involved in providing training and consultation.

A project steering committee comprised of the Program Director, Sex Offender Specialist, consulting psychologist, Adolescent Clinic staff, administration from Green Hill, and two other DJR staff with expertise in sex offender treatment will assist the implementation of the model. A 2-week "start-up" period will be established for all project staff to be oriented and receive initial training.

A psychologist with special expertise in juvenile sex offenders will be hired on contract to provide 6 hours per week to the project. His or her role will be to train staff, provide consultation on a regular basis as part of the treatment team, assist in implementing the treatment model, and provide individual evaluations as needed.

A clinician with skill in behavior modification techniques for sex offenders will also be hired on contract to teach selected project staff these skills and to monitor their use. An estimate of time contracted is 20 hours of initial training, with 3 hours of monthly consultation thereafter.

Data Gathering/Evaluation Design

Data gathering and program evaluation would occur on an ongoing basis. In addition, a long-range study of the project's effectiveness would be made. There would be three major directions for the research efforts:

1. Pre-post measurement of each client's functioning on multiple dimensions. These would include sexual arousal pattern (i.e., plethysmograph testing), social skills, sexual knowledge, sex role attitudes, aggressive ideation and behavior, locus of control, attitude toward victims, and degree of responsibility accepted for the offense and its consequences. These would be assessed at entry and at the time of transfer from the residential phases. They would also be assessed during Phase Three (community supervision) 6 months into the parole period. Additional followup

testing would occur after discharge at 1-, 2-, and 5-year intervals.

2. Relationship of change in each dimension to recidivism. Multivariate analysis would be made of the degree of change in each area as correlated to the rate of reoffense. This would be done both on an individual basis (i.e., looking at these data for each project "graduate") and as a group (examining the relationship for groups as a whole who have changed on various dimensions to recidivism). This analysis would be done after each youth's discharge from the program at 1-, 2-, and 5-year intervals.

3. Overall impact of the project on recidivism. This would be accomplished by comparing the project youths' overall rate of reoffending to the rate of reoffending of similar offenders who did not have the same treatment exposure. This would be done at 1-, 2-, and 5-year intervals when aspects cited in items 1 and 2 were also being analyzed. In addition, this aspect of the project would be reexamined 10 years after the first group had completed treatment, providing a meaningful longitudinal evaluation of project impact on sexual assaultive behaviors.

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CHAPTER 2

METHODOLOGICAL AND ETHICAL ISSUES IN EVALUATING AND TREATING ADOLESCENT SEXUAL OFFENDERS

Judith V. Becker, Ph.D., and Gene G. Abel, M.D.

The exact incidence of sex crimes committed by adolescent offenders is unknown. Incidence figures are available from several sources. Using victim reports, the National Crime Survey indicates that for 1979, adolescent males committed 21 percent of the forcible rapes in this country. That amounts to 200 forcible rapes per 100,000 adolescent males. The Uniform Crime Report arrest data through 1980 indicate 50 arrests for forcible rape per year per 100,000 adolescent males. These statistics, however, only reflect crimes of forcible rape. Adolescent offenders engage in other deviant sexual behaviors involving victims that do not meet the criteria for forcible rape, such as child molesting, exhibitionism, frottage, and sodomy.

Ageton (1983) conducted a survey using a national probability sample of male adolescents aged 13 to 19. For purposes of her study, Ageton defined sexual assault as all forced sexual behavior involving contact with sexual parts of the body. Included in the definition was rape, incest, sodomy, and fondling. Exhibitionism and any other act that was not a "hands-on" experience was excluded. Of a sample of 863 adolescent males, the rate of sexual assaults per 100,000 adolescent males ranged from 5,000 to 16,000. The highest rate was for 17-year-olds. The incidence rates varied as a function of the definition of sexual assault and whether one relied on arrest rates or self-report data of the offenders.

Even though we do not have the exact incidence figures for sex crimes committed by adolescents, we do

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know that the average adolescent sexual offender may be expected to commit 380 sex crimes during his lifetime (Abel, Becker, Cunningham-Rathner, Rouleau, Kaplan, Reich 1984). These figures indicate that it is imperative to develop effective assessment and treatment strategies for adolescent sex offenders.

In designing research proposals and implementing treatment strategies for adolescent sexual offenders, there are several methodological and ethical issues that must be addressed.

Methodological Issues

Normative Adolescent Sexual Behavior

A crucial issue in working with adolescent males who have been charged with committing a sexual offense is determining what normative sexual behavior is for them. A goal for the clinician is to differentiate DSM III-diagnosable paraphiliacs from nonparaphiliacs who are engaging in exploratory sexual behavior. Major confusion surrounds the identification of adolescent sexual offenders. Some surveys (Finkelhor 1981; Roberts et al. 1973) suggest that adolescents charged with sexual offenses may have been involved in innocent sex play. Others have demonstrated that adolescents have committed violent sexual offenses (Deisher et al. 1982; Groth 1977; Markey, 1950). An important research issue relates to defining normative adolescent sex behavior and those variables that predispose the adolescent to develop a deviant sexual interest pattern and to reoffend.

Defining the Issue To Be Studied

Many of the studies conducted to date in the area of sexual assault either have failed to define what is meant by a sexual assault, have combined all forms of assault under one heading, or have failed to count some deviant behaviors as assaults because they have not met certain legal criteria. In conducting a survey or assessing adolescent sex offenders, the behavior to be studied must be defined specifically.

If one wishes to determine the number of deviant sexual behaviors or offenses committed by adolescents, the adolescents should be questioned about all the possible paraphilias, not just the behavior that has come to the attention of others. For example, an adolescent should be asked whether he has made obscene phone calls, worn or used objects for sexual purposes (fetishes), engaged in voyeurism (peeping through windows), masturbated in public, exposed himself, engaged in frottage (rubbing up against a victim for sexual satisfaction), touched a younger child in a sexual manner or had a younger child touch him or her, engaged in incestuous behavior, forced sex on a peer or older person, or engaged in sadistic behavior. If the adolescent is asked general questions, he is very likely to respond with general answers, concealing the various paraphilias in which he has participated because the behavior is illegal and he may feel embarrassed by or at risk about disclosing such behavior.

Of the 306 sexual offenders we have evaluated whose first deviant arousal began before age 18, 15.4 percent had the primary diagnosis of female nonincest pedophile; 21.2 percent were male nonincest pedophiles; 8.8 percent were female incest pedophiles; 2.6 percent were male incest pedophiles; 4.9 percent had the primary diagnosis of rapist; 13.1 percent were exhibitionists; 7.2 percent were voyeurs; 5.9 percent were frotteurs; and 20.9 percent had other paraphilias (Abel, Becker, Cunningham-Rather, and Lucas 1983).

The data also indicate a tremendous overlap across diagnoses (Abel, Mittelman, Becker, Cunningham-Rathner, and Lucas 1983). These findings suggest that clinicians should conduct a very thorough assessment of all sex offenders to identify other types of undisclosed sexual offenses. Unless a thorough assessment is conducted, the extent and frequency of the deviant behavior will not be determined.

At the Sexual Behavior Clinic, we question the subject/patient on several points: (1) whether he has actually engaged in any of the DSM III categories of paraphilia; (2) whether he has attempted a deviant act but not completed it; (3) what percentage of his fantasies are deviant; (4) how many deviant acts he has committed on how many

victims; and (5) whether or not he has been arrested for any of the deviant behaviors.

Sample Population

Incidence and frequency figures vary depending on the sampling procedures. Most of what we know about sex offenders comes from studies of incarcerated offenders. One could be misled by relying on the verbal reports of incarcerated offenders or those offenders under a mandate to receive assessment or treatment since such offenders are caught in a Catch-22 situation. If they tell the truth about their sex offenses, they may be charged with other crimes and have their prison sentences extended.

Researchers and clinicians should consider whether the adolescent is under the supervision of criminal justice services or is not known to criminal justice and has volunteered for assessment/treatment on his own or at the request of his parents. The degree of the adolescent's willingness to volunteer for assessment or treatment will have an impact on the information to be disclosed.

A Model and Test of the Acquisition of Deviant Behavior

The reasons that adolescents first commit sex crimes as well as how they maintain their deviant behaviors are unknown. Lacking in the field of adolescent sex offenders is a model empirically derived and tested. We propose a social learning theory model to explain the acquisition and maintenance of deviant sexual arousal. According to this theory, individuals are not born with complex repertories of behaviors but learn them (Bandura 1973). The behavior can be learned by a number of modes. For example, the sexual offender may have observed aggressive behavior within his family or peer group or by characters depicted in the mass media (Bandura 1983; Wolfgang and Ferracuti, 1967; Zillman 1983). A survey of 131 adult sex offenders seen at the Sexual Behavior Clinic indicates that 89.3 percent had been hit as children by their parents and 42 percent had parents who fought violently. Being the victim of physical or sexual aggression may also predispose an individual to model that behavior. We found that 29 percent of

our subjects had sex forced on them when they were children (Abel, Becker, Cunningham-Rather, and Lucas 1983).

Since not everyone who has been physically or sexually abused develops a deviant arousal pattern, other events must occur to facilitate the development of these aberrant interest patterns. A second factor relates to recall of the initial deviant sex act during masturbation-orgasm activities. Pairing or bonding of the deviant fantasy and sexual excitement during masturbatory activity give the fantasy greater erotic power (Abel, Becker, and Skinner 1983; Abel and Blanchard 1975).

A third element relates to the person's ability to relate to other members of society. If an adolescent has grown up in a home without good role models for functional, social, and assertive behavior, he will have difficulty relating to his peer group on a functional level. The isolation and possible rejection that occur may lead the adolescent either to socializing with young children and then eroticizing his interest in them, or to using force in sexual interactions because of his deficit in obtaining consensual sexual relations with a peer.

Critical to the development of a deviant sexual interest is what the offender says to himself about his behavior. Before the offender translates his fantasies into acts, he anticipates that positive consequences will result from his behavior and that negative consequences to himself or his victim will be minor. These cognitive distortions are a result of limited sexual knowledge, a lack of empathy for the victim, a limited understanding of sexual values, and faulty perceptions about his own experiences as a victim. If the sexual offender engages in a deviant sexual act and there are no negative consequences for that behavior, the behavior is rewarded and the offender is motivated to commit further offenses.

The following case is offered in support of this model:

David was first seen at the Sexual Behavior Clinic at age 16. During the clinical interview, David reviewed that at age 10 he had been sodomized by his 30-year-old uncle. David reported that he had not disclosed the assault to his mother or any other family member because he was terrified of his uncle and feared that

he would do him further harm. David had continuous nightmares about the assault and experienced flashbacks of the event. When David reached puberty, he began to have sexual fantasies about sexual involvement with 8- to 10-year-old boys and girls. At age 15, he was arrested for sexual abuse of one female child and two male children. During the clinical interview, David related that his nightmares about his own victimization and the flashbacks stopped when he became the victimizer.

David had an identical twin brother named John. We requested that John come to the clinic for the interview. John had not been victimized by the uncle or by any other adult, nor had he engaged in any deviant sexual behavior or used deviant sexual fantasies. David, however, had been sexually victimized and then went on to use deviant sexual fantasies and to act on those fantasies. The behavior appears to be related to David's memories of his own victimization and masturbatory fantasies. Maintenance of his interest was associated with his continued masturbation.

To test the social learning theory model or any other model, one must develop measurement instruments or use instruments with demonstrated reliability or validity. With such instruments, the treatment needs of adolescent sex offenders can be determined, as well as the treatment outcome.

Clinical interviews. The clinical interview is the most popular and relied-upon method for both diagnosing and assessing clients and for assessing treatment outcomes. The major problem in relying solely on the clinical interview is that the adolescent offender may underreport the extent of his deviant acts or deny the existence of a deviant arousal pattern. An attempt to establish the reliability of the information obtained involves having a colleague conduct a second interview or reinterviewing the adolescent at a later date.

At the Sexual Behavior Clinic, we have used a standardized, structured clinical interview with adolescent offenders to obtain various information:

1. number of categories of deviant sexual interests
2. order of importance of deviant sexual interests
3. number of reported victims of sex crimes by category
4. number of completed sex crimes by category
5. duration of deviant sexual interests by category
6. reported use of sexually deviant fantasies
7. personality characteristics
8. effects of alcohol and pornography on deviant sexual behavior
9. quality of social, assertive, and empathic skills
10. presence of nondeviant sexual behavior and interest
11. degree of force used during the commission of sexual crimes by category
12. reported ability to control deviant sexual interests

Information obtained during a clinical interview may be checked for validity against arrest records or with the offender's parents if they are reliable informants. A major problem in using the first form of validation, however, is that adolescents are likely to have engaged in considerably more offenses than the number for which they have been arrested. And since the adolescent keeps his deviant sexual interest pattern secret, it is highly unlikely that the adolescent's parents or guardians will be able to provide the type of information necessary to validate the offender's statements. There are other assessment techniques, however, that may be used to validate information obtained during the clinical interview.

Paper and pencil tests. Since sex offenders have distorted cognitions about the appropriateness of a variety of sexual interests, it is important to evaluate their

cognitions about their behavior. A method of doing this is to survey adolescents about their most common cognitive distortions, then tabulate the distortions and convert them into a scale. The statements may deal with such issues as the ability of children to give consent to sexual activities, the dangerous consequences of child molestation to the victim, and so forth.

The scale should then be administered to a comparison group of nonoffending adolescents and to the sex offenders to determine if the scale discriminates between the two groups. If it does, then it can be used as an assessment instrument and a therapy outcome measure. There will be a problem in finding a comparison group of nonoffending adolescents, however, since most school systems will not permit recruitment of adolescents to participate in research where they may be asked questions about sexual thoughts or practices. This, of course, is a major obstacle in validating many of the assessment procedures for use with adolescent sex offenders.

Clinicians have commented on adolescents' deficit in sexual knowledge. In working with adolescent sex offenders, the McHugh Sexual Knowledge Inventory, Form Y, can be used. This test has been validated on high school students and can be used as an assessment of adolescents' sex knowledge, as well as an outcome measure for those testing programs with a sex education component.

A quick, valid, reliable, and inexpensive method of assessing various deviant sexual interests is a card sort of sexual interests. This instrument may be developed by collecting from sex offenders brief phrases that they report as reflecting their deviant interests and that they find most arousing. The card sort should cover all DSM III paraphilias, and the sex offender would rate on a Likert scale how arousing the phrases were.

To assess social and assertiveness skills in offenders, one may videotape their responses to structured scenes involving a confederate. The tapes can then be rated using a Heterosocial Skills Scale (Barlow et al. 1977). This scale has norms for a nonoffender population. Various paper and pencil assertiveness and social competency scales may be administered.

For those working from a biological or genetic model of sexual deviancy, appropriate neurological tests with known validity and reliability should be administered. For example, Berlin and Meinecke (1981) report that of 17 consecutively referred patients with sexual disorders, 14 had either a genetic, hormonal, or neurologic anomaly, including elevated testosterone levels, brain damage, dyslexia, and Klinefelter's syndrome. Berlin suggests that biological vulnerabilities may predispose some individuals to develop deviant sexual arousal patterns. Berlin notes, however, that further confirmation with a control group must be attained.

Thomas and Rogers (1983) describe a treatment program for intrafamily juvenile sexual offenders. These clinicians conceptualize the problem as being multifaceted, complex, and indicative of interpersonal dysfunction as well as disrupted family functioning. Accordingly, their assessment battery includes the WISC-R or WAIS, Bender-Gestalt, Rorschach Ink Blot Test, Thematic Apperception Test, Minnesota Multiphasic Personality Inventory, and the Family Adaptability and Cohesion Evaluation Scale. These are standard psychological assessment tests. It would be intriguing to see if those tests with a known sensitivity and specificity reveal different profiles for nonoffenders and offenders and whether therapy effected a change in those profiles.

In summary, regardless of the model one is testing, assessment procedures should have a known reliability and validity and should either discriminate between offenders and nonoffenders or be sensitive as a therapy outcome measure.

Psychophysiologic assessment. As noted previously, accurate clinical interviews are hampered when sex offenders attempt to conceal their true deviant interest patterns. Paper and pencil testing, on the other hand, also has limitations in that it can be falsified depending upon the subject's degree of cooperation. The most accurate and objective means of evaluating male sexual arousal is to measure penile responses directly while presenting various stimuli depicting deviant sexual interests (Abel et al. 1981; Zuckerman 1971). It is possible to measure and differentiate objectively a variety of deviant interests using this technique.

At the Sexual Behavior Clinic, we have been using two forms of physiologic assessment: Slow Physiologic Assessment (SPA) and Rapid Physiologic Assessment (RPA). SPA consists of presenting 2-minute audiotaped descriptions of various sexual behaviors while the patient's erection response is measured with a penile transducer. We have used this method with more than 800 sexual offenders, including 30 adolescent offenders. Recently we evaluated the reliability of a subset of stimuli with 108 adult sex offenders. The Cronbach's Alpha coefficient of reliability for all but one factor was .89.

The RPA involves presenting film slides of 10 categories of behavior: (1) adult female, (2) adult male, (3) young female, (4) young male, (5) neutral, (6) frottage, (7) exhibitionism, (8) sadomasochism, (9) adolescent female, and (10) adolescent male. These slides are presented for a 7-second interval while the subject's erectile response is measured. To date, we have administered this assessment procedure to 244 adult male sex offenders. The reliability of each category was calculated. Rotation of the factor mean yielded three factors: a female factor reliability = .94; a male factor = .90; and a neutral factor = .56. These data indicate that the procedure is a reliable tool with which the clinician can elicit information about sexually deviant arousal. Both these assessment techniques can also be used to increase the validity of sex offender diagnosis (Abel, Cunningham-Rathner et al. 1983).

We recently completed an experiment in an attempt to improve the validity of the traditional clinical interview (Abel, Cunningham-Rathner, Becker, McHugh 1983). Ten adolescent males, aged 13 to 17, and 80 adult males who received an evaluation at the Sexual Behavior Clinic were (1) reinterviewed using the structural interviews, (2) reminded that data were protected by the Certificate of Confidentiality, (3) given feedback on their paper and pencil and psychophysiologic test results, and (4) asked to explain the discrepancies between test results and initial clinical history. Of the 90 subjects, 50 reported additional paraphiliac arousal following this debriefing. Additional diagnosis showed that 1.1 percent of the arousals were revealed because of reiteration of confidentiality; 18.9 percent because of feedback on card sort responses; 20 percent as a result of being reinterviewed with the structured

clinical interview; and 62.2 percent because of feedback on the psychophysiologic assessment.

Ideally, in validating an assessment instrument, one would want to have a nondeviant (normal) comparison group to whom to administer the procedures. In working with adolescent sex offenders, it is difficult if not impossible to gather such a comparison group and obtain permission to assess their arousal patterns. In our society, adults are uncomfortable with the notion of childhood and adolescent sexuality, even though there is literature to indicate that children are sexual at a very early age (Langfeldt 1981). There is also an ethical issue related to exposing nonoffender adolescents to deviant sexual stimuli.

For those interested in further information on how to operate a behavioral laboratory to evaluate sexual offenders, Laws and Osborn (1983) provide detailed instructions. Freund (1981) has written an excellent review on assessment of pedophiles and addresses the issue of deception (faking arousal responses), as do Earls and Marshall (1983).

Treatment Strategies

Unfortunately, a controlled group outcome study has not been conducted to date to assess the effectiveness of a specific treatment strategy for adolescent sex offenders. For the past 8 years, we have been conducting federally funded research projects to develop an effective treatment for adult sex offenders, with the ultimate goal of reducing sex offenses. As cited previously, we found that approximately 58 percent of our adult offender population has the onset of their paraphiliac arousal pattern prior to age 18. If we are to reduce the incidence of sexual victimization in this country, we must treat sex offenders early in their careers of paraphiliac behavior.

Evaluating the effectiveness of treatment programs for adolescent sex offenders is difficult for several reasons: (1) there are a limited number of treatment programs for sex offenders in this country; (2) valid dependent measures have not been reported by any adolescent treatment program; and (3) there have only been two controlled group outcome studies conducted with sex offenders to date.

Knopp (1982) describes nine treatment programs for adolescent sex offenders. These programs outline what the originators feel are the clinical treatment needs of juvenile sex offenders. They include (1) getting the adolescent to admit his problem, (2) working through the offender's own victimization extensively, (3) sex education and values clarification, (4) cognitive restructuring, (5) disruption of the offender's use of deviant fantasies antecedent to committing sexual offenses, (6) assertive and social skills training, (7) reenactment of the crime with a mannequin, and (8) generation of guilt to reduce the likelihood of recurrence.

Only two outcome studies have been completed with sex offenders. Doshay (1943) treated 256 juvenile sex offenders; and although some of his cases do not fit the current DSM III classification of paraphilia, his study is important in that he treated a large number of offenders and determined recidivism at least 6 years later. The main element of his treatment was generating guilt in the offender.

The treatment involved bringing the boy's family and the boy into an open discussion of the youth's sexual offense, then mobilizing the cultural forces taught the adolescent through the acculturation process and the family. Although Doshay and no control group and relied only on arrest records as a dependent measure, he found that of 108 people who were exclusively sex offenders, only 2 had reoffended prior to adulthood and none had committed sex offenses as adults. Only 14 of the adolescent offenders who were not exclusively sex offenders reoffended prior to adulthood, and only 10 reoffended as adults. Although these are probably underestimates since not all sex offenses lead to arrest, the results are still impressive.

The second controlled outcome study was conducted by the authors. One hundred and ninety-four child molesters were entered in a behaviorally oriented treatment program. Treatment was conducted on an outpatient basis and lasted for 30 sessions, each 90 minutes long. Treatment consisted of six specific elements, and each element was completed during five 90-minute sessions. The elements were covert sensitization, satiation, sex education, cognitive restructuring, social skills, and assertiveness skills training. Subjects were treated in groups, and each group

was randomly assigned to treatment components. Subjects were assessed pretreatment and after every 10 therapy sessions. They were also evaluated at 6-month and 12-month followup interviews. For a detailed description of the treatment program, see the manual. The Treatment of Child Molesters (Abel et al. 1984).

All subjects volunteered for treatment, and confidentiality was protected by a Certificate of Confidentiality. At this writing, 106 subjects have completed treatment, and only 1 subject has reoffended (99.1 percent success rate). Six months after completion of treatment, 58 subjects had been reevaluated and 52 had stopped engaging in deviant sexual behavior (89.7 percent success rate). Thirty-three subjects had completed the 12-month reevaluation, and 25 of them had not engaged in deviant sexual behavior (75.8 percent success rate). These data indicate that sexual offenders can be treated effectively in an outpatient program.

Lacking in the literature is a controlled group outcome study with adolescents. A modification of the adult treatment package needs to be assessed with an adolescent population.

Any research conducted to evaluate the effectiveness of treatment strategies should (1) use a homogeneous sample, (2) use a standardized measure of treatment outcome, (3) utilize a control or comparison group, (4) not rely exclusively on arrest records as an outcome measure, (5) ensure adequate followup, and (6) evaluate whether the offender is in an environment where reoffending is possible.

Ethical Issues

Disclosure of Information That Is Unknown to the Criminal Justice System

In working with adolescent sex offenders, the issue of confidentiality is particularly crucial because of the nature of past criminal offenses they may have committed without being apprehended. The following case exemplifies such an issue:

Rich was an 18-year-old boy who was referred by Dr. B., a colleague, for voyeuristic behavior. Rich had been treated by Dr. B. for 1 year, and therapy then terminated. Several months after the termination, Rich was rearrested for voyeurism. He then contacted Dr. B., who referred him to this writer. During the initial interview, Rich related that the deviant sexual behavior began when he was 15 years of age. He had been arrested approximately 2 years after the onset and began therapy at that time. Rich reported that even while he was in therapy, he continued to engage in voyeuristic behavior. Leaving his home in the evening and looking in windows while masturbating, Rich continued the behavior while in therapy and denied engaging in it even though his therapist questioned him about it.

From the age of 15 until 18, Rich engaged in voyeuristic behavior three times a week. Yet he had been arrested only twice. In disclosing that information during the initial interview, Rich would have been at risk had a prosecutor elected to subpoena the records. The criminal justice system could have obtained information about Rich that they did not previously have.

Some therapists have dealt with this issue by not keeping any written records. While this method safeguards the client's confidentiality, it places a burden on the therapist to have to recall the fine details of each patient's history. Furthermore, if the client elects to reenter therapy several years later, no record exists, and both the client and the therapist must again rely on recall. Rada (1978) reports that some therapists and institutions keep two sets of records, one for their personal use and one for public use.

For the past 5-1/2 years, we have conducted clinical research projects involving the assessment and treatment of sexual offenders on an outpatient basis. To handle the issue of confidentiality, we have used the following system. All history and material disclosed by our clients are coded, using a special identification number. The client's name and identification number are held by a colleague who resides in another country. Thus, if the client forgets his identification number, his coded file can be retrieved by contacting our colleague. Consequently, sensitive information will not be available to anyone unless the client

discloses his code number. All coded files are kept in locked file cabinets.

Clients are also instructed not to tell anyone connected with their evaluation/treatment about the specifics of any illegal acts. For example, we request that clients not tell us when the illegal act occurred, what time of day, where, who the victim or victims were, and what they looked like. By not recording the specific details of an illegal act, we safeguard the client's confidentiality. Furthermore, we have a Certificate of Confidentialty from the National Institute of Mental Health that has protected us from testifying in any court about the specifics of any evaluation or treatment conducted in our clinic.

Disclosure of Detailed and Specific Information Unknown to the Parents That They May Wish to Access

It is not uncommon for adolescent sex offenders to fail to reveal their behavior to their parents or guardians and to deny totally the crimes with which they are charged. It is imperative that the clinician ascertain what the adolescent has revealed to his parents or guardians.

Once the adolescent has revealed what his fears are--specifically, what the parents would do or how they would respond if they knew--his permission should be sought to discuss these fears with the parents or guardians. If the parents assure the therapist that they will not act on the adolescent's fears, permission should be obtained to discuss the undisclosed information with the parents. If the adolescent does not give permission for disclosure of the information, such disclosure to parents/guardians is not recommended since this might jeopardize the client-therapist alliance.

This issue may be addressed, however, by having the adolescent and his parents sign a consent form before evaluation and treatment are initiated. Such consent forms specify that information revealed to the therapist will be coded and held in confidence and that only the adolescent will know the code number. This procedure informs the parents/guardians in advance that specific history given by the adolescent will be held in confidence and not made available to them.

Permission may be sought from the adolescent to give his parents general feedback on the results of the evaluation and/or treatment. We have never had a parent/guardian request specific feedback. Usually, when parents accompany their adolescent to a session, they ask only general questions, such as "How's my son doing?"

Working With the Adolescent Sexual Offender Under a Mandate to Receive Treatment

In working with adolescent sex offenders, therapists may find themselves faced with patients who are mandated to receive treatment. Sometimes the adolescent will be remanded to an institution for therapy or to an outpatient facility. In such cases, the right of society to be protected must be weighed against the rights of the individual. Frequently, therapists in institutional settings are faced with having to serve the needs of the patient as well as those of the institution.

From an ethical point of view, it is advisable that the therapist develop a contract with the adolescent or with him and his parents. Such contracts establish what behaviors are expected of the patient and what the therapist's function will be. In this manner, the patient and his family know exactly what to expect in terms of treatment. The therapist should also inform the patient how reports to the criminal justice system will be handled. At the Sexual Behavior Clinic, we have a policy of sharing with the patient all reports that have been requested about him.

A major ethical issue for those adolescents under a mandate to receive treatment is that they indeed receive the most efficacious treatment strategies to aid them in learning to control their deviant sexual arousal patterns. Readers are referred to two excellent chapters on ethical issues in working with children and youth in group-home treatment settings (Timbers et al. 1981) and legal and ethical issues in mandatory treatment (Bohmer 1983).

Possible Risks in Assessment and Treatment of the Adolescent Sexual Offender

In assessing sex offenders, we have identified four risks:

1. information unknown to the criminal justice system may be disclosed;

2. the adolescent may feel uncomfortable or anxious or may become depressed as a result of discussing his deviant sexual interest pattern;

3. the adolescent may contract a venereal disease in the course of the psychophysiologic assessment; and

4. the adolescent may feel uncomfortable in completing the various paper and pencil tests.

To minimize these risks, we have taken the following steps. In regard to risk 1, all history data and other material disclosed by our patients are coded. Regarding risk 2, patients do in fact feel uncomfortable, anxious, and occasionally depressed about disclosing their deviant behavior. Consequently, any individual treating adolescent offenders should be skilled in treating anxiety or depression in case those symptoms develop. Regarding the third risk, none of the more than 850 patients we have assessed has developed a venereal infection from the penile transducer, because we have developed and followed a sterilization process. With respect to risk 4, some patients are indeed uncomfortable in responding to the subjective assessment because they are, in fact, revealing their deviant arousal and behavior patterns. Again, it is important that the clinician be trained to handle such problems.

A final issue regarding assessment relates to exposing the adolescent to explicit sexual cues. We do not expose the adolescent to material any more violent than what is presented daily on television and in the movies. To ensure that patients do not acquire any faulty cognitions or deviant behaviors, we recommend that adolescents be debriefed following the assessment.

The only risk we have identified for the adolescents who have participated in our treatment program is discomfort in carrying out the masturbatory satiation treatment. If an adolescent or his parents find masturbation objectionable for moral, physical, or religious reasons, we have not required the patient to perform that therapy. Instead, the adolescent satiates his deviant fantasies by just talking them into the tape recorder without masturbating.

Conclusion

Assessment and treatment of adolescent sex offenders are a relatively new but enormously important field. If we are to reduce victimization in this country, we must pay attention to prevention and treatment for those individuals at risk of offending and reoffending. Research efforts should focus, first, on defining the extent of the problem and, second, on evaluating assessment and treatment strategies. There will be some difficulty in developing reliable and valid assessment instruments since comparison groups will probably not be readily available because of the sexual nature of the area under study. Treatment designs will be limited since it is unethical to deny or withhold treatment to adolescents at risk of reoffending. Given these limitations, there is still room for factors that instigate and maintain deviant sexual arousal patterns. Primary prevention measures can then be directed at eliminating the causes of sexual aggression.

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CHAPTER 3

THE ADOLESCENT SEXUAL OFFENDER: BACKGROUND AND RESEARCH PERSPECTIVES

Robert E. Freeman-Longo, M.R.C.

A National Concern and Problem

In recent years more concern and attention have focused on the juvenile offender than at any other time in this Nation's history. It is no surprise that a major focal point is the adolescent sexual aggressor. If one were to trace the case types in the juvenile justice system, it would become apparent that juveniles are entering the system in increasing numbers for committing sexual offenses.

In 1890 we found no record of juveniles committed to the Oregon juvenile justice system for sex crimes. In the nineteen sixties there were just a few adolescent sex offenders. In the nineteen seventies we began to see an increase in juveniles committed for sexual crimes. Here in the nineteen eighties we are shocked to find adolescents committed not only for rapes and child sexual abuse charges but rape murders as well (Neilson 1984).

National figures indicate that 90 percent of all criminals begin their deviant behaviors between the ages of 12 and 16. Abel (1984) reports that of the paraphilias, those offenders under the age of 18 commit an average of 6.75 crimes per offender, while adults committing similar crimes commit an average of 380 crimes per offender. O'Shaughnessy (1984) states that most violent crimes are committed by offenders between 16 and 25 years of age.

Prior to 1975, few if any specialized programs for treating adolescent sex offenders existed in the United States. By the nineteen eighties several States had developed adolescent sex offender programs in both inpatient and outpatient settings (Knopp 1982). Even with such efforts, these programs have only begun to scratch the surface of the treatment problem. As is true of programs

in existence since the nineteen sixties that treat adult sex offenders, neither enough programs nor beds are available for the increasing numbers of these offenders. Programs that currently treat adolescent sex offenders are, in many cases, just part of a larger facility treating juvenile offenders of all kinds and have limited space assigned for sex offender treatment. The majority have anywhere from 8 to 20 spaces and a long waiting list.

The greater number of States are at a loss for funds and/or resources to develop specialized programs for the adolescent sexual offender (ASO). Training centers, juvenile detention centers, and similar facilities have traditionally been ineffective in treating the ASO (Freeman-Longo 1981).

Case 1

> Bill is a 15-year-old white male charged with sexually abusing a teenage girl. He was arrested and convicted in juvenile court. Bill was sent to a training school for 1 year but, because of the lack of specialized treatment programs, was released with little attention paid to his sexual deviancy. Within a few months, Bill had cut off his sister's underwear with a pair of scissors and attempted to rape her.

While faced with significant numbers of juvenile offenders (Uniform Crime Reports and other national crime reporting sources indicate that nearly 20 percent of sex offenses are committed by offenders under 18 years of age), political red tape and bureaucratic blocks have all too often tended to prevent institutions and agencies from developing separate and specialized programs. In addition, staff in these agencies and institutions either lack the necessary knowledge and training to treat these offenders or have not chosen to view the problems of ASOs as serious enough to warrant specialized programs or treatment. Of even greater concern and consequence is the juvenile justice system, which, in many States, hosts inadequate laws to address the problem of ASOs. As recently as April 1984, an adolescent in Oregon was charged with multiple sexual crimes and assaults and was released to the community because juvenile laws prevented him from being held. All too often, these offenders are labeled as having an "adolescent

adjustment reaction," and their sexually assaultive behaviors are written off as experimentation, nuisance behaviors, and the like. In such instances it is not uncommon to find the disposition of these cases resulting in minimal to nonexistent intervention or supervision.

Another area of concern is the undetected ASO being processed through the juvenile justice system without the problem being identified. This often happens when ASOs are processed for other crimes or problems, such as dependency cases or ungovernables (Honorable Jeanne Dawes Crenshaw 1982).

Case 2

> Martin is a 14-year-old white male. He was referred to juvenile court for unruly behavior. While obtaining a history on Martin, it became apparent that he was acting out sexually on his sisters. As the case was to determine the presence of ungovernable behaviors and make a disposition, the sexual acting out was not addressed. Martin was referred to a foster home with no recommendations for counseling or treatment.

A trained social worker may obtain a detailed history reflecting sexual deviancy in the adolescent's past as well as a background of sexual abuse. As a result of overloaded court dockets and a need to process cases in a timely fashion, these issues are seldom addressed in the final disposition of such cases. Other warning signals indicating the adolescent's potential to become or continue to be a sexual aggressor are often overlooked, ignored, or not even recognized.

Case 3

> Sam is a 12-year-old black male with a history of making obscene phone calls and voyeurism of his sisters. His parents tried everything from locking him in his room to counseling. Finally he was arrested for exposing himself and was required to obtain counseling by the juvenile court. He was terminated by the therapist 1 month later and diagnosed as "adolescent

adjustment reaction." By the age of 15 he had committed his first rape.

As this trend continues, we find an increasing number of ASOs going through a judicial revolving door, only to be tried as adults for a violent sexual offense or returning to the justice system as adults for committing numerous sex offenses.

Researchers and clinicians working with sexual aggressors have found that over 50 percent of adult sexual offenders began their sexual deviancy during their adolescent years and, in some cases, during childhood (Abel 1984; Groth et al. 1982; Longo 1982; Longo and Groth 1983). Studying a sample of 137 convicted sex offenders in Connecticut and Florida, Groth, Longo, and McFadin (1982) found that the average age at first offense among rapists was 18.78 and among child molesters, 23.8 years. The same study revealed that the age range for first offense for both groups was 8 to 50; the modal age was 16. Abel, Rouleau, and Cunningham-Rathner (in press) found that over 50 percent of sexual offenders had developed their deviant arousal pattern prior to the age of 18. In some geographic locations, figures indicate that over half of child sexual assaults are perpetrated by offenders under 18 (Groth and Loredo 1981). In an unpublished study of convicted rapists and child molesters, Freeman-Longo (1983) found that the average age at which sexual offenders began to have deviant sexual fantasies was 15. Longo (1982) found that the average age when juvenile sexual offenders began to masturbate was 12. In a study of 231 adult, convicted sexual offenders, Longo and Groth (1983) found that 30 percent reported a history of compulsive masturbation.

In addition to finding that most sexual offenders begin their abusive and deviant behaviors during adolescence, research indicates that the majority have also been sexually, physically, and/or emotionally abused or neglected during the developmental years. A study of 90 convicted sexual offenders, both adolescents and adults, revealed that 95 percent experienced some form of abuse or neglect (Freeman-Longo 1981). Several ongoing studies are confirming that the majority of sexual offenders had been sexually abused or traumatized (Groth 1979; Groth and Longo 1985; MacFarlane 1983; Prendergast 1979). In a study of 156 convicted sexual offenders and 49 drug

abusers, Groth and Longo (1985) found that 80 percent of convicted sexual offenders reported a history of sexual abuse or trauma in their lives compared to 29 percent of the drug abusers in the same study. Fifty-six percent of the sexual offenders reported a hands-on victimization. MacFarlane found that 80 percent of incestuous fathers had been sexually abused or traumatized during their lifetimes. One noticeable difference between males who are sexually abused and eventually become sexual abusers themselves and those who are sexually abused and do not become abusers is the frequency of victimization. Clinical observations indicate that male sexual offenders who report sexual abuse in their histories experienced multiple victimizations. This phenomenon appears less prevalent in the histories of males who, although sexually abused, did not engage in sexually abusive behavior toward others. Thus, it appears that sexual abuse is a key risk factor in the etiology of sexually aggressive behavior.

In addition to abusive factors in their histories, this author finds that the majority of sexual offenders have deviant thinking patterns. The adolescent offender, sexual aggressive or otherwise, also displays thinking errors common to criminals who develop during early childhood (Goodman 1983; Samenow 1984a; Yochelson and Samenow 1976). In The Criminal Personality, Yochelson and Samenow identify 52 separate thinking errors common to criminals. These 52 thinking errors have been condensed and reduced to 17 common errors readily identifiable in sexual offenders, both adolescent and adult, by Bush (1983) and Conner (1984). Samenow (1984b) says that "the habitual offenders' twisted moral outlook is firmly rooted by the time they are six or seven years old, and early treatment in programs has the best chance of success". . . . "If you want to change them, you're going to have to help them change the way that they think" (1984b).

> As early as the preschool years, patterns begin to unfold that become part of the criminal life style. As a child, the delinquent is a dynamo of energy, a being with an iron will, insistent upon taking charge, expecting others to indulge his every whim. He takes risks, becomes embroiled in difficulties and then demands to be bailed out and forgiven. No matter how much his parents try to understand and guide him, they are thwarted at every turn. They assume that this

> waywardness is merely a stage of development and therefore do not perceive that this is a pattern that is evolving. . . . Most of those who flirt with danger do not become outlaws. They discover that breaking away from legal and moral restraints exacts too high a price. For a criminal, it's just the opposite (Samenow 1984b, p. 7).

The presence of criminal thinking errors has a direct link to development and maintenance of deviant sexual thoughts and fantasies.

As already mentioned, the onset of deviant thoughts and fantasies is often at puberty and, in some cases, even earlier. If one agrees to the theory that deviant sexual behavior is learned, then the observation of deviant sexual fantasies and criminal thinking patterns at an early age becomes even more significant. When behavior is addressed, there are accompanying thoughts and attitudes that cannot be overlooked. If an adolescent has been entertaining deviant sexual fantasies, it becomes apparent that the offender has a distorted thinking process that condones the continuation of deviant thoughts, fantasies, and behaviors.

Case 4

> Wayne was 5 years old when he recalls having his first thoughts about strangling women. He attempted to strangle a friend's mother prior to the onset of adolescence. When the woman reacted, he lied by telling her he was just playing. He recalls having these thoughts throughout his developmental years until he raped and strangled his first victim at the age of 17.

This distortion in thinking makes it easier for the adolescent to do away with the morals and values that would otherwise result in feelings of guilt or disgust with his or her own deviant thoughts and fantasies. When thinking errors are present and fantasies occur, which are then reinforced by masturbatory activity, a very powerful learning process takes place. As one offender stated:

> I remember I used to relieve my feelings of anger by masturbating. One time I was caught masturbating by

my parents and they called me a "little bastard" while spanking me. As soon as they left my room I began to masturbate again, saying to myself "I'll show you . . . I'll show you" and I can remember the good feeling I had in relieving my anger in this fashion. Later I began to pair this feeling with masturbating to fantasies of molesting little boys" (Freeman-Longo 1980).

The incidence of abuse in the histories of ASOs and the development of criminal thinking patterns would have to be written in many volumes to address these issues in detail. These particular areas appear to be key risk factors in the origination of sexual aggression. Other historical and environmental factors that may put the individual at greater risk also need to be acknowledged. One such factor is the placement of juveniles in agencies, institutions, foster care, group homes, training schools, and the like.

A child is often labeled a behavioral problem or ungovernable or is removed from a home because the parents or primary care takers are discovered to be abusive or neglectful. When placement in a relative's home is not possible, the child is placed in an institution or setting such as those just mentioned. While the actions of the courts and social service agencies are supposedly in the best interest and welfare of the child in question, the end result of such placement is often disastrous to either that child or other children.

If an abuser is placed in such a setting, there will usually be other children in that setting for different reasons who, if not already victims, may become victims in time. Many ASOs are readily able to target potential victims, and children who have been victimized before are often the easiest marks. Cases of physical or sexual abuse by one child on another are commonplace in these settings. In a study of 41 convicted sexual offenders, Freeman-Longo (1983) found that 90 percent had been abused in some fashion. Nine offenders, or 22 percent of the sample, had been sexually abused in foster homes and institutions. In addition, national figures reveal that as many as 75 to 80 percent of runaway children, often placed in these settings, have been the victims of sexual abuse or attempted sexual abuse.

If we in fact put child victims at a greater risk of being victimized by placing them in such settings, and if placing ASOs in these settings supplies them with more victims, it is clear that this process must change. These data support the notion that victims of abuse need to be housed separately, despite labels of ungovernable, runaway, and so forth. As a society we need to begin to examine the possibility that ungovernable behavior, runaway behavior, truancy, and the like may very well result from abuse. This premise generally holds true with the ASO. If an adolescent has a documented history or even a strongly suspected one of sexually abusing others, we must begin to push for separate and specialized housing and treatment. Mixing these two populations together only stands to victimize abused children further while perpetuating the sexual deviancy of the ASO, as the following case illustrates.

Case 5

> Brian is a 16-year-old white male who was placed in a training school for sexually abusing other male children. On numerous occasions Brian was caught being aggressive with other male children and adolescents in the boys' bathroom and shower areas. As it turned out, Brian was housed with other male children who had been sexually abused. Eventually, through informal talks and group discussions, Brian found out about some of the other male residents' victimizations. Brian saw these children as easy targets and finally admitted to being sexually aggressive toward them.

Cases such as the preceding one are common. If we are ever to break the abusive cycle and work toward helping the ASO, we have to recognize and acknowledge real problems and the errors we have made in the past; we must accept the reality of this most serious issue.

Research Perspectives

Studies such as those cited in the preceding section are only a fraction of the research conducted and the information made available to professionals, agencies, and government programs looking to address the problem of

ASOs. Concerned professionals and agencies unfortunately report all too often that while they are aware of the problems and some of their causes, their hands are tied when it comes to taking some form of action. With the multitude of information delivered in the media and in seminars, lectures, and so forth, one is still faced with headlines such as "State Shields Teen Accused of Sexually Molesting Child" or "Youth Acquitted in Rape of Girl." Legislation passed to address this problem seldom mandates research, nor does it appropriate moneys to conduct research or gather data. Programs and agencies constantly complain about increased caseloads and lack of time, resources, and support to gather and publish data.

Although local and State programs and agencies are trying to address the problem of ASOs, little national attention has been drawn to this issue. If we are to understand this problem and begin to combat it, we must make a national effort to establish programs and research the area extensively. A great deal of information has been published on the adult sexual aggressor, but little has been written on the adolescent perpetrator of sexual crimes. The following addresses suggested research areas with respect to the ASO in terms of etiology, identification, and treatment.

Most clinicians working with sexual aggressives would probably agree that the problem usually begins in childhood or during adolescence. We are able to point out numerous risk factors in the making of a sexual offender, although little can be determined as definitive causes. Therefore, etiology needs further investigation. Samenow (1984) suggests that criminal thinking patterns begin during childhood. Numerous authors report that abuse in the background of offenders is commonplace. Clinicians usually agree that sexual deviancy is a learned behavior. The question arises of how these and other factors interrelate and culminate in sexual aggression. It appears that this question could best be addressed by research on both the ASO and the adult sexual aggressor. The adolescent whose experience is fresh and problems acute can offer us insight into how he feels as a teenager with multiple problems and what childhood events may have led to his deviancy. The adult offender can tell us what he recalls about his childhood and adolescent years and its carryover into adulthood.

Etiology is therefore a key area in understanding both adolescent and adult sexual aggressors and what leads to sexually deviant behavior. Key research areas follow.

The spectrum of abuse. How does sexual, physical, and emotional abuse or neglect tie into the individual turning toward sexual aggression? What differences, if any, are there between the child who is abused and does not grow up to be an abuser and the one who is abused and does become an abuser?

Parental bonding. Is there a lack of parental bonding that is a risk factor in sexual abusers? What differences, if any, are there between sexual offenders, nonsexual offenders, and a "normal" population?

Role modeling. If sexual aggression is indeed a learned behavior, what are the negative influences with respect to role models that have an impact on the ASO's behavior?

Social skills deficiencies. Most sex offenders, both adult and adolescent, are socially maladjusted and come from chaotic backgrounds. What social skills deficiencies are common among sexual aggressors? Are there differences between perpetrators who assault children and those who assault adults? At what stage of development do these deficiencies become apparent?

Emotional development. What emotions are arrested in the sexual offender? At what ages? Special attention should be paid to anger and fear. Would an androgynous upbringing affect sexually aggressive behaviors in males?

Thinking patterns. What types of thinking errors appear in sexual offenders? When do the errors begin, and how are they maintained? What roles do these thinking errors play in the development and maintenance of deviant sexual thoughts and fantasies?

Sexual development. How does the offender learn about sex? What types of distortion and mislearning take place? What kinds of experiences occur that lead to aggressive sexuality? What types of sexual interests develop

and under what conditions? What are the arousal patterns? What is missing in the offender's overall understanding of human sexuality? How does sex education at an early age affect sexually aggressive behavior? Many appear to have polymorphous sexual interests and/or histories of being sexually precocious.

Self-concept. When does the offender's self-concept take a turn for the worse and under what conditions? What key factors lead to the development of a low self-concept, which in turn affects sexuality and aggression? What deficient areas of self-concept are common among sexual offenders?

Moral development. What problems in moral development are evident in sexual aggressors? These areas can be explored in the works of noted experts such as Piaget and Kohlberg.

Value structures. Many offenders have different value structures than "normals." Their value structures are distorted, minimal, or nonexistent. How does value structure affect aggressive and sexually aggressive behavior?

Social relationships. The majority of sexual offenders are isolates. To what degree do these individuals lack relationships with parents, siblings, and peers?

Other Theories About Causes of Sexual Deviancy

Some researchers, such as Fred Berlin, suggest that sexual deviancy is a biomedical problem. Others suggest that it is linked to mental illness, organicity, and so on. What percentage of sexual aggressors can attribute their problems to such causes?

Deviant cycles. All adult sexual offenders have a preassault cycle and a deviant cycle. Are there similarities or differences among these cycles, and are they apparent in ASOs? To what extent are they similar or different from those of adult sexual offenders?

Arousal patterns. Are arousal patterns present in the adolescent sexual offender? When do deviant arousal patterns begin to develop? Is there arousal to their own

sexual victimization, as occurs in the adult offender? What percentage of ASOs show arousal to their own sexual victimization? Why do some ASOs become aroused at their own sexual victimization while others do not?

These areas need to be explored further to determine their relationship to the etiology of sexual aggression. To form more conclusive data, such research should be aimed at six target groups: (1) the adolescent sexual offender, (2) the adult sexual offender, (3) the adolescent nonsexual criminal, (4) the adult nonsexual criminal, (5) the noncriminal adolescent, and (6) the noncriminal adult. To refine these data further, it will be important to conduct such research with various minority groups and with both males and females. These types of data can best enable professionals to begin identifying the potential sexual aggressor through observing early warning signals.

Another promising area for research is early warning signals for identification, especially if standardized tests are developed and validated, tests that would help target sexual aggressives or potential sexual aggressives. Therefore, subsequent research areas might include the following:

Criminal background. Are there criminal charges or illegal activities in the histories of sexual aggressors that precede sexually deviant behaviors?

Progression of sexually deviant behaviors. Different schools of thought exist in this area, too. Some researchers find little progression in sex crimes, while others find progression to be the rule. Data in this area vary, and in some cases the variation is large. Is there, in fact, a noticeable progression from "nuisance" behaviors, such as frottage, obscene phone calling, exhibitionism, and the like, to the more serious, hands-on assaults? Is this progression evident in the ASO?

Deviant behavior patterns. What types of deviant behaviors, assaultive or otherwise, are exhibited by the offender? At what ages do these behaviors become evident? How frequently are they exhibited? What have the parental, institutional, legal, and societal responses been to such behaviors? Have they been reinforcing?

The victims of these behaviors. What age groups and sexes are most frequently targeted by ASOs? Are the same individuals revictimized? Does the ASO tend to target strangers rather than individuals he knows?

The thinking patterns and fantasy structures of the ASO. Are there significant data to indicate that the ASO begins to develop deviant thinking patterns during childhood and adolescence that are directly linked to sexually aggressive behavior? At what ages do these offenders begin to have thoughts or fantasies of a sexually deviant nature? Are there identifying behaviors that accompany these thoughts and fantasies?

Sexual deficiencies and abnormalities. While the sexual revolution is touted as having made America a sexually permissive society, many ASOs do not feel they have permission to be completely open and honest in talking about their sexuality, especially if there are deviant components. With respect to deficiencies in sex education, which are prominent among ASOs? Various types of sexual dysfunction, such as impotence and premature ejaculation, and sexual practices such as masturbation, especially compulsive masturbation, are present among ASOs. What links are there between these behaviors, problems, and practices and deviant thoughts and fantasies?

Pornography, violence, and the media. Although researchers find more and more links between pornography, violence, and the media (e.g., TV), there is no universal agreement that these are causative factors in sexually deviant behavior. What do convicted ASOs and adult sexual offenders claim about using these materials and the roles they play in their deviance? How does this compare to nonsexual criminal groups and noncriminal groups? Does this material affect criminal and deviant thinking patterns, or do deviant and criminal thinking patterns distort this material, encouraging its misuse?

Social behaviors. What types of social behaviors appear to be central to ASOs? What types of activities should they be engaging in that they are not? What types are they participating in that they should leave alone? What can we do, if anything, to effect needed changes in children and adolescents to avoid major social skill deficiencies?

Literature on the treatment of sexual aggressives is scarce. What there is focuses primarily on the adult offender. This indicates one of two major problems: (1) little research is being focused on treating sexual aggressives; or (2) though studies on treating sexual aggressives are being conducted, either formally or informally, few researchers or clinicians are writing about their work. One major problem common to most programs that treat sexual aggressives is the lack of program evaluation and followup studies. Such programs continually face extinction when they cannot justify their effectiveness. Research on treating ASOs and followup studies are now essential as we begin to address the ASO problem. Several research areas should be considered:

Physiological assessment. The majority of sexual aggressives are aroused by deviant sexual stimuli, and many have polymorphous interests. Physiological assessment with the penile plethysmograph has been done on adult offenders for years. Use of physiological assessment with ASOs is not as common, and no standards or norms have been established for assessment. Ethical considerations must also be addressed with this procedure.

Aversive counterconditioning. Behavioral treatment methods can be employed in conjunction with the penile plethysmograph. Ethical considerations and types of treatments also need to be researched and tested.

Behavioral therapy. Behavioral therapies, including covert sensitization, assisted covert sensitization, masturbatory satiation, masturbatory reconditioning, sensate focus, and the like, have all been proven effective with adult sexual offenders. Two concerns about using these treatments on ASOs need to be addressed: (1) What are the ethical concerns surrounding such treatment with ASOs? (2) How effective are these methods with ASOs?

Offender age. In developing and maintaining treatment programs for ASOs, the questions of age differences and which age ranges to treat create continuing debate and concern. Should one mix preadolescent offenders with ASOs? Many institutions classify youthful offenders as being between the ages of 16 and 24. Should people of this wide an age range be mixed in the same program? At what age should we begin to treat children and preadolescents?

Other treatment methods employed with both adolescent and adult sex offenders, such as psychotherapy and educational modules, are relatively standard and proven both necessary and effective.

Summary

It is apparent that we can gather the most information and broaden our data base and knowledge by doing research with both adolescent and adult sexual aggressors. In addition, clinicians must begin to focus on (1) long-term followup with treated and untreated sexual offenders and (2) the development of standardized program evaluation criteria. Richard Freeman (1984) suggests that evaluations should indicate three major components to any effective sex offender treatment program:

1. program continuity and consistency in treatment
2. a multiple treatment modality approach
3. a drug and alcohol treatment/education component

If in fact this position is true, it seems apparent that initial research should include the following: (1) Client followup with programs that have been in existence for at least 5 years and have maintained a consistent approach to treating sexual aggressives, both adolescents and adults. Programs using a multiple modality approach should be given priority consideration for followup studies. (2) Evaluation of programs that meet the criteria of item 1 should be conducted to evaluate the effectiveness of treatment modalities. Questions to be addressed are: (a) Is there any specific order in which treatment methods are executed? (b) Are treatment methods delivered in a consistent fashion? (c) What modalities and methods appear most effective in treating sexual aggressors—specifically, the ASO? (d) What selection criteria, if any, are used in determining which offenders are treated in that particular program?

If the answers to these questions and those cited earlier about etiology are found, our knowledge will guide us properly in addressing the problem of adolescent sexual offenders and related social issues. Our final concerns may very well regard whether attention will be paid to this

problem nationally and whether funds will be made available to combat it.

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CHAPTER 4

ADOLESCENT SEXUAL OFFENDERS: AN OUTPATIENT PROGRAM'S PERSPECTIVE ON RESEARCH DIRECTIONS

Michael O'Brien

The conspiracy of silence that for so long hid the tragedy of sexual victimization has been broken. We are witnessing a national revolution in our awareness of the problem and in the mobilization of professionals from many disciplines to combat it. The sexual abuse of children, in particular, has lately received unprecedented media attention in contrast to an earlier time, when the notion of children as victims of sexual abuse was unthinkable because it was believed unlikely.

This attention has largely focused on adult perpetrators of incest and child molestation and on child victims of the same. Coming to the attention of legal and human services professionals just recently is the problem of adolescents who engage in sexually victimizing behaviors. There has been a longstanding reluctance to view the issue of adolescents who rape, molest, or commit other sexual crimes as a serious social concern. The adolescent who committed a sexual offense was typically considered an awkward explorer in the unknown territory of his emerging sexuality. Consequently, acts for which adults faced prosecution and imprisonment were dismissed if perpetrated by adolescents. This emerged from misguided beliefs about the behaviors being temporary developmental anomalies or from equally misguided attempts at sparing adolescents a social stigma.

The phenomenon of adolescent sexual offending is not an insignificant one. While accurate incidence statistics are understandably lacking, some figures do point to its prevalence. Ageton (1983) estimates that over 500,000 adolescents commit sexual assaults in this country every

year. This figure underestimates total adolescent sex offenses since her definition is limited to the use of force in committing acts that involve contact with sexual parts of the body. Excluded are reports of exposing, voyeurism, obscene phone calls, and other "hands off" offenses. Victims of sexual abuse seen at Children's Hospital in Washington, D.C., report that adolescents represent the majority of their assailants (Groth and Loredo 1981).

Data from the St. Paul, Minnesota, Police Department reveal a steady increase in the number of adolescents arrested for sexual offenses.

Year	Number of Adolescents Arrested*
1979	38
1980	50
1981	75
1982	70
1983	92

*These figures do not include prostitution or incest arrests.

Between 1979 and 1983, there was a 142 percent increase in the number of male adolescents arrested for committing a sex offense. In 1983, juveniles accounted for 40 percent of the total arrests for sexual offenses excluding prostitution in St. Paul and 61 percent of the total arrests for sexual offenses other than rape. The overwhelming majority of these involved child molestation. The seriousness of the problem is further underscored by studies indicating that nearly half of adult sexual offenders report their offense history began when they were adolescents (Groth and Loredo 1981).

The increase in awareness of the problem has resulted in an unprecedented interest nationwide in establishing treatment programs. Efforts have generally been frustrated by the paucity of professional literature, especially empirical research, on the subject. One recent, computer-generated literature search (Med-Line) on the topic of child sexual abuse, cross-referenced with the topics of sexual offenders and pedophilia, revealed only one reference on adolescent sex offenders from over 100 articles

indexed. A great deal of research needs to be carried out in this area so that efforts at intervention, treatment, and prevention can be effectively designed and evaluated.

Useful information has been gathered by the few treatment programs that have been serving this population for the past several years. Their experience in assessing and treating sexually offending adolescents and their families point to research topics and concerns that need to be studied. The purpose of this chapter is to draw from our experience in treating male adolescent sexual offenders in a community outpatient setting to raise research questions and suggest research directions.

Program for Healthy Adolescent Sexual Expression (PHASE)

The Program for Healthy Adolescent Sexual Expression (PHASE) was begun in 1981 in response to increased recognition in the communities of urban and suburban St. Paul, Minnesota, of the extent of the problem and the lack of appropriate resources to deal with it. PHASE is an outpatient program of a small, suburban private mental health clinic (East Communities Family Center) that historically had served primarily delinquent youth and their families. The program has two basic components: The Education-Assessment Program and the Treatment Program.

The Education-Assessment component lasts 5 weeks and involves individual and family interviews, the completion of various psychological instruments, and four 2-hour groups made up of approximately 10 adolescent males, ages 13 to 18. The groups focus on issues in adolescent sexuality, with primary emphasis on sexual attitudes, values, and social influences on behavior. The program provides an education in sexual victimology and the differentiation between healthy, appropriate sexual behavior; unhealthy, inappropriate sexual behavior; and criminal sexual behavior. Each adolescent is required to share his story a number of times with the group, to explain why his behavior was inappropriate, and to describe how it affected his victims. In addition, each member assesses his need for further treatment and begins to formulate treatment goals. He is helped in this task by soliciting feedback from

each of the other group members. Parents also meet in the Parents' Group to offer support to one another and to learn some of the same information being taught their sons.

The Education-Assessment Program culminates in a diagnostic conference involving the juvenile probation officer, social worker, and/or other involved professionals. There, the case manager reports on his or her assessment of the adolescent and his family and makes treatment recommendations. A formal comprehensive assessment report is also completed at this time and forwarded to the court or referring social agency. Assessment dispositions include: (1) termination from the program because the Education-Assessment Program is believed sufficient; (2) termination and referral to other outpatient programs (i.e., family counseling, social skills groups, etc.) or to treatment (inpatient or outpatient) for chemical dependency or mental illness; (3) referral to an inpatient or residential program for adolescent sexual offenders because the youth is considered too risky for outpatient treatment or in need of more intensive long-term treatment; and (4) referral to the PHASE treatment program.

The Treatment Program lasts an average of 6 additional months and involves individual, family, and group pyschotherapy. The adolescent moves through a four-stage treatment model in this program. Stage I--Acceptance--requires him to assume primary responsibility for his sexually abusive behavior. This stage involves breaking through defense mechanisms so the adolescent arrives at an understanding of how his behavior hurt the victims and why it is a serious problem. Stage II--Consequences--increases the adolescent's understanding of the impact of his sexual offenses on the victims by requiring him to write and share a letter to his victim(s). He is also asked to confront his own experience as a victim of sexual, physical, or emotional abuse and must demonstrate appropriate empathy for others in family and group therapy. Stage III--Understanding and Change--involves increasing the youth's awareness of his own emotional, psychological, and situational processes that led to his offenses and requires him to develop appropriate alternative behaviors. During this stage, he develops a context in which to view his offending pattern more clearly through exploring the influences of his family, peer, and social systems on his behavior. He must clarify the cognitive, behavioral sequences that led to

his sexual acting out (i.e., arousal patterns, reinforcers, and fantasies) and must learn ways to "short-circuit" the sequences to prevent the offending behaviors. During this stage, he learns to identify the underlying needs for affection, competency, power, acceptance, dominance, nurturance, etc., that the sexually abusive behavior may have been serving. He learns to identify and report stressful, high-risk situations and their accompanying feelings. The final goal of this stage is to develop a number of alternative behavioral options to his previously inappropriate attempts at meeting his needs and to rehearse these alternatives in individual, family, and group therapy.

Finally, Stage IV--Support--encourages the adolescent to increase his knowledge of and ability to meet his own sexual and interpersonal needs without victimizing others. He must learn appropriate, need-fulfilling strategies and demonstrate them in treatment. General areas for skill building during this stage include assertiveness, communication, expression of feelings, impulse control, academic and vocational interests, and social skills, including dating and involvement in peer activities outside of treatment.

At PHASE, we view the involvement of the family in the treatment process as crucial, since the family provides the major context in which the sexually victimizing behavior is learned and expressed. The family is also likely to be the key source of conflict and tension for the adolescent. Family therapy follows from the family assessment completed during the Education-Assessment Program. Typical goals include developing effective family communication; increasing family intimacy, especially between father and son; restructuring interpersonal boundaries; realigning family roles; working through unresolved abuse issues in the family; and enhancing family esteem.

Since the summer of 1981, PHASE has worked with over 250 male adolescent sexual offenders in providing assessment and treatment services. The majority of the youth (80 percent) were direct referrals from the juvenile courts. An additional 10 percent were police "court diversion" referrals, and 10 percent were referrals from other social services agencies or treatment programs or were self-referred. The average age of the client is 15.5 years, but there are virtually equal proportions of youths aged 14, 15, 16, and 17. Ninety percent are white; 10 percent are

black or Hispanic. At intake, 72 percent of the referrals were living with one or both birth parents, while 28 percent were living in residential facilities, group homes, foster homes, or with other relatives. The residential locations of our clients were 37 percent urban, 27 percent suburban, and 36 percent rural or small town.

The referring offenses involved noncontact offenses (obscene phone calls, exhibitionism, voyeurism) (14 percent); molestations involving sexual contact (i.e., fondling, oral-genital contact) (53 percent); and more aggressive sexual assaults involving penetration (33 percent).

The majority (64 percent) of the victims of the adolescent perpetrators were younger children, whose average age is 6. Twenty-four percent of the victims were peers, and only 12 percent were adults. In 17 percent of the cases, the victim was a member of the perpetrator's family.

School performance was above average in only 5 percent of the clients, average in 32 percent, and below average in 63 percent.

The majority had been involved in some prior treatment or therapy (53 percent) (not sex offense-specific) and had had contact with some aspect of the social service system prior to their sexual offense (52 percent).

Assessing the Problem

When first confronted with the adolescent offender, the clinician must begin to assess the nature and scope of the problem. The first question is, Does the particular behavior or set of behaviors exhibited by this adolescent reflect relatively normative exploration, given developmental imperatives; or does it represent the early stages of an emerging sexual deviance syndrome or sexual maladjustment? The terms sexual offense and sexual offender are legal designations, not clinical ones. The fact that a law has been broken and an adolescent apprehended and adjudicated ought not to be prima facie evidence of psychopathology. In Minnesota, an adolescent who is more than 36 months older than a person with whom he has sexual contact is, by law, a sexual offender. In such a case, a particular sexual act, while criminal by legal definition,

may represent a single episode of relatively benign sexual exploration that does not call for the perpetrator's participation in a lengthy course of treatment. A brief sexuality education program may be entirely appropriate. On the other hand, a behavior that appears relatively benign on the surface may, after more extensive investigation, represent a serious developing sexual problem that requires a comprehensive treatment program. Clearly, a set of guidelines must be developed to differentiate those adolescents whose behavior signifies a more serious problem and who are at higher risk for reoffending from those whose behavior reflects developmentally normal drives, perhaps inappropriately expressed, requiring, at most, an educational rechanneling.

Once it is determined that a significant sexual offense problem exists, the next major question is, What types of treatment methodologies in which treatment setting are appropriate for this particular case? This raises the issues of outcome research. The question gets translated into, How effective are we with which kinds of clients in which settings after which therapeutic procedures, and how does the change occur? There are many methodological, ethical, and pragmatic concerns that outcome studies generate; suffice it to say that this ought to be a primary focus of the research.

The clinician must be careful in working with adolescent sexual offenders not to reduce the phenomenon to a single explanation or a single diagnostic category, and so must researchers. We must guard against making simplistic assumptions about the homogeneity of the population and about parallels to adult sexual offenders that are not warranted or supported by data. Adolescent sexual victimization is a multifactor, multicausal phenomenon. What is called for is the development of an empirically based, differential classification typology to guide clinicians in formulating treatment goals and planning treatment strategies.

The adolescent males we have treated in PHASE appear to fall into six broad groups based on their behaviors and associated personal and family variables. These are:

1. Naive Experimenters
2. Undersocialized Child Exploiters

3. Sexual Aggressives
4. Sexual Compulsives
5. Disturbed Impulsives
6. Peer Group-Influenced Offenders

Naive Experimenters

Peter, age 13, was asked to babysit his mother's friend's 4-year-old girl Alicia. This was Peter's first experience with babysitting since he was an only child who had not previously been afforded the opportunity to care for a younger child. At bedtime, while helping Alicia to dress in her pajamas, he found himself becoming curious and having "urges." He then laid on the bed with her, kissed her on the lips, and gently began to stroke her stomach, working his way down into her pajamas. After a brief period of genital fondling, he stopped because he felt guilty. The next morning Alicia nonchalantly told her mother that Peter had kissed her and touched her between her legs. Alarmed, the mother called Peter's mother and the local sexual assault center, who reported the incident and referred the family to PHASE.

The adolescent naive experimenters generally are younger boys (aged 12 to 15) who have no previous history of acting-out problems and who have adequate social skills and peer relationships. They are usually members of fairly stable families who are unlikely to have been victims of physical or sexual abuse. They tend to be sexually naive and unsophisticated young people who engage in a single event or a few isolated events of opportunistic sexual explorations with a young child (usually 2 to 7 years of age). The event is situationally determined (i.e., often while babysitting) and is effected without recourse to any force or threats. When confronted, the naive experimenter may deny his offense but usually comes to admit his responsibility shortly, feeling remorseful and embarrassed in the process. These adolescents are typically dismissed at the end of the Education-Assessment Program.

Undersocialized Child Exploiters

> Jerome, age 16, could best be described as a loner. He had virtually no close peer friendships and only a few casual peer acquaintances. He spent a good portion of his time watching television or playing video games on his home unit. When outside playing, he was likely to be off by himself or with considerably younger children. He was viewed by the adults in the neighborhood as polite and quiet--a nice boy. They didn't know that he had been involved sexually with seven of the neighborhood children. The sexual abuse involved fondling and oral-genital contact, which he tricked and manipulated the younger boys into doing with him. While no force or threats were used, he did maintain secrecy with the children by warning them that they would be in trouble with their parents if they told. The secret was broken by one of the children, and Jerome was apprehended, charged, and adjudicated and referred to the PHASE program as a condition of his probation.

The undersocialized child exploiter also engages in sexual behavior with younger children, but his behavior goes beyond mere experimentation and exploration. It is likely to reflect a more chronic pattern of sexual behaviors with children, a pattern that is effected through manipulation, trickery, enticement, or entrapment and that involves primarily fondling and oral-genital sexual contact.

The hallmark of this group is their chronic social isolation. They are not accepted by their peers and are unlikely to have a best friend agemate. They may have been the victim of frequent family moves in their formative years that precluded the establishment of close friendships. Since they lack adequate social skills, they remain isolated from their peers and then gravitate to younger children, who accept them and even admire them.

These boys evidence an abysmally low opinion of their own worth as a result of alienation from family and friends; they are likely to perform poorly in school. There is rarely a history of other antisocial behaviors or problems with police or school authorities. Involvement with drugs or alcohol is unusual.

For this youth, feelings of inadequacy and insecurity predominate, and there is a distinct tendency toward withdrawal and depression, especially when stressed. Recurrent anxieties and irritabilities typify his emotional life. His apparent apathy and passivity represent attempts at concealing his extreme sensitivity and resentfulness. The undersocialized child exploiter is a sad young man who feels misunderstood, unappreciated, and demeaned by others. He has a generally pessimistic and disillusioned outlook for his future. Unless his self-esteem can be enhanced and appropriate peer relationships established, he runs the risk of continuing to be attracted to young children as sources of fulfillment of his needs for affection, acceptance, competence, and power and would likely act out sexually with children as well.

His family is characterized by an emotionally and often physically distant or absent father and an overwhelmed, anxious, or depressed mother. There is likely to be little expression of emotional warmth or nurturance in the family. Generally, the family system could be described as intact but disengaged.

A comprehensive treatment program involving individual, group, and family therapy is called for with this type. Generally speaking, an outpatient program providing these components is appropriate unless the pattern of offending suggests a high likelihood that the client will act out again if left in the community even though undergoing treatment. A residential program is then most appropriate.

Sexual Aggressives

Tony, age 15, is a victim of physical abuse at the hands of his alcoholic father. His mother is passive and ineffectual and suffers from the physical beatings of her husband as well. Tony has been involved in frequent brushes with the authorities for fighting, theft, vandalism, and truancy. After school, he assaulted a 14-year-old girl under the stairwell and forced her to perform fellatio on him at knifepoint. He was arrested that night, detained, and later convicted of first-degree criminal sexual conduct. He was referred to PHASE for assessment.

These adolescents use force or violence in committing sexual assaults against peers, adults, or older children. They are usually products of disorganized and abusive families.

Differentiating them most clearly from the former type is the fact that they are likely to be very much involved with a peer group, although probably a delinquent one. They do possess adequate social skills and may even be somewhat charming and socially gregarious. They are likely to have girlfriends and to be socially and sexually active.

They are typified by a history of antisocial behaviors stemming from early childhood. They have difficulty handling aggressive impulses and deal poorly with anger, getting themselves in frequent fights with family members and peers. They are also prone to be heavily involved with alcohol and other mood-altering substances.

The sexually aggressive adolescent acts out sexually to express anger or to humiliate, dominate, and control. There is a high probability that he learned to connect violence with erotic arousal, so that more violent sexuality is preferred to a gentler expression. He may fantasize about committing rape and acts of cruelty, torture, or even murder.

The sexually aggressive adolescent generally has poor impulse control, is often tense and anxious, and may experience vacillation of powerful moods and emotions. He has a difficult time accepting criticism, being overly sensitive to others' opinion of him. He has a tendency to use denial and projection to avoid accepting responsibility for his self-destructive and victimizing behaviors. In short, the sexually aggressive adolescent could be described as an antisocial, character-disordered young man who, in all probability, will continue to act out without intensive long-term treatment, most appropriately in an inpatient or residential setting.

Sexual Compulsives

David, age 16, by most accounts was considered an exceptional teenager—a straight A student, active in

church youth activities, star of the high school football team. However, David was identified by three different women as the man who had exposed himself to them while they were having their morning jog. While at first denying their accusations, David gave in to the weight of evidence against him and admitted that he had exposed himself regularly to a number of women while performing his morning 5-mile run. This behavior had gone on unabated for over 8 months before he was apprehended and referred for treatment.

The sexually compulsive adolescent engages in repetitive, sexually arousing behaviors that become compulsive or addictive in nature. The offenses are usually hands-off behaviors, such as voyeurism (window peeping), obscene phone calling, exhibitionism (exposing), and fetish burglary (i.e., stealing women's underwear). Most adolescent sexual compulsives are quiet and withdrawn. Often, they are quite bright and studious as well. They tend toward overachievement and perfectionism and are likely to be overconforming to social standards and conventions. This hypersensitivity to failure results in a constant state of tension and anxiety from which they seek emotional release.

Another related characteristic of this group is their inability to express negative emotions, especially anger, in an appropriate manner. The profound emotional constraint and accompanying anxiety result in tension-reducing, acting-out behaviors that involve sexual arousal. The behavior becomes patterned, cyclical, and repetitive because it is self-reinforcing. It is also self-generating in that it ultimately results in increased anxiety, fear, and self-condemnation from which the adolescent feels compelled to escape.

The family systems of such youths are generally rigidly enmeshed, with closed external boundaries. Parents are often emotionally and behaviorally repressed and are likely to adhere to a rigid and fundamentalist religiosity.

Disturbed Impulsives

George, age 17, was becoming more reclusive and strange with each passing day. In the night he heard

"satanic voices" that told him to do evil deeds. He tried to resist; he prayed for angelic assistance but to no avail. Each night he walked into his 14-year-old sister's room and uncovered a part of her body—usually a hand or foot--and then masturbated, until he ejaculated on the exposed appendage. He was also driven impulsively to dress occasionally in his mother's or sister's underwear. He was referred for evaluation after his sister reported him to a counselor at school.

The disturbed impulsive type of adolescent sexual offender is a category reserved for those adolescents whose impulsive, sexually offending behavior signifies an acute disturbance of reality testing due to mood-altering chemicals or mental illness. The offense may be a single, unpredictable, uncharacteristic act, or it may be one of a pattern of bizarre and ritualistic acts. The sexual offense reflects a malfunction of normal inhibitory mechanisms due to a thought disorder caused by psychosis (either endogenous or drug induced).

This young person needs an inpatient program that can treat his chemical dependency and/or mental illness. Medications may be required to control this adolescent's psychotic thinking.

Peer Group-Influenced Offender

Todd, age 15, was pleased with the fort he and his friends had just completed. While returning from a trip to the store for pop and candy, he and his friend Jason met Barb, a 14-year-old girl in whom Todd had recently taken considerable interest. Barb agreed to have a look at their fort. After a few minutes inside, the three were joined by Tim, Mark, and John, who had assisted in the fort project. Without warning, Tim lunged at Barb and ordered Mark to block the door. John held Barb's legs while Tim pulled up her shirt and began fondling her breasts. He then unfastened her pants and began to fondle her genital area. Barb kicked and screamed. Todd, fearing the censure of his peers, joined in the victimization. He did not realize the seriousness of the behavior in which he was engaging. All the boys were arrested and adjudicated in

juvenile court on sexual assault charges. Todd was referred to PHASE as a condition of his probation.

The distinguishing feature of the peer group-influenced offender is that his sexually victimizing behavior, which is acted out in a group setting, is a function of peer pressure. This adolescent responds to the influence of social conformity in engaging in sexual offenses. The motivation for the behavior derives from a desire to gain peer attention, recognition, or approval. Even when he understands the behavior to be wrong, he feels pressure to go along with the gang so as not to risk social censure or ridicule.

The peer group-influenced offender is typically a youth who has a normal social background and who likely has little history with the criminal justice system. More importantly, he seldom brings to the assessing clinician much of a history of other sexually deviant acts. The presenting offense is most likely his first offense of a sexual nature.

The clinician must be careful, however, to carry out an extensive and comprehensive evaluation of the client when conducting assessments on youth in this group. There are some perpetrators, especially the group leaders (i.e., Tim in the illustrative case), who may more accurately be classified as sexual aggressives in light of other past behaviors and personality and family dynamics, even when their behavior occurred in a group context. There is a tendency for group offenders to deny or dilute their own responsibility for their behavior by parceling it out among the other participants. They reason that if the whole group participated in the behavior, that somehow makes it less serious and less wrong. The sexually aggressive adolescent may attempt to legitimize his own deviant behavior by influencing others to engage in it with him.

If this is a single, isolated event with few other associated offender dynamics, the youth may be appropriate for a shorter therapeutic intervention, such as the Education-Assessment program, provided other legal consequences are applied as well. However, if the assessment reveals that there is evidence of other sexually aggressive events, then more extensive treatment may be required.

It must be stressed that we view this as a working typology that seems to reflect the various adolescent sexual offenders that have been referred to our program in the past 3 years. It has undergone expansion and refinement from an initial two-type classification (i.e., undersocialized--nonaggressive and socialized--aggressive offenders; see O'Brien 1982) and is certain to be refined and defined further. In one sense, it is merely one way of slicing up the pie. A classification schema could be based on a number of different factors, such as personalities, types of offenses, types of victims chosen, family dynamics, attitudes, and so on. Still, it is a starting point for beginning to answer some basic research questions about this population.

Several other research questions have been stimulated by our work with the clients of PHASE.

1. What is the role of family dynamics in the etiology of adolescent sexual offenders? Why does the role of the father appear so critical among this population? A common thread that seems to connect the various types is the generally poor relationship between father and son, if it exists at all. How different is this from nonoffending teens or delinquent teens in general? What implications does this issue have for the increase in female-headed households and for minority, especially black, families where this is a prevalent condition? What impact does this have on attitudes toward women, sexuality and sexual roles, parenting, and so forth?

2. What roles does pornography play, if any, in the development of sexually deviant behaviors of adolescents? The majority of adolescent males admit to having some experience with so-called soft-porn magazines. Many of our adolescent offenders have had easy access to hard-core pornography, and many, having access to VCRs, have viewed XXX-rated movies at home or in the homes of friends and relatives. What influence does this have, if any, on attitudes toward women, violence, and sexuality, and on sexual behaviors?

3. A related issue requiring study is the whole question of the influence of sexual attitudes on the commission of sexually victimizing behaviors. Do the sexual attitudes of the adolescent offenders differ significantly from those

of their nonoffending peers? from those of other delinquent adolescents? from those of the various types of offenders? How are their attitudes formed, and how do they influence sexual acting-out?

4. Our society has undergone a shift toward greater tolerance and acceptance of premarital sex and sexual variations in the past few decades. Do adolescents feel an increased pressure to become sexually active with their peers? If so, what impact does this have on the less well socialized teens who do not have the opportunity for sexual experimentation? What is the media's impact on the sexual values and behaviors of adolescents?

5. Taking off in quite a different direction, what is the impact of sexual repression on sexual victimizing behaviors? Might repression of sexual feelings, thoughts, and urges play a significant factor in sexual offense behaviors? For instance, the sexual aggressives in our program are significantly less likely to admit to regular masturbation than the child sexual exploiters. Is this merely denial, or does the blocking of sexual urges result in a greater likelihood of committing certain sexual offenses?

6. Closely related to sexual repression is the whole issue of sexuality education's impact on adolescent sexual behavior. While most of our adolescents report that they had a sexuality education course in their schools, sexual myths and misinformation abound in this population. Would a better sexuality education curriculum--one that goes beyond the anatomical "plumbing" to discuss sexuality in more detail and to raise the issues of sexual values and ethics--affect sexual behavior among adolescents in a positive direction? Might such a curriculum prevent some sexually abusive behaviors?

7. What role does the adolescent's own experience as a victim of sexual abuse and physical abuse play in his offenses? It has been a commonly held belief among many professionals that the adolescent sexual offender is merely a sexual victim working out his own victimization experiences. Yet the majority of our offenders are not victims of sexual abuse. Clearly other factors are at work with them.

Those of us who have been working with adolescent sexual offenders over the past several years have been playing it by ear for the most part. We have drawn from our experiences with adult sexual offenders and our clinical work with adolescents and families to create hypotheses and develop models to assess and treat them, and we feel we are doing a good job of it. Now we must begin to validate our hunches, hypotheses, and models by undertaking sound and comprehensive research. Our clinical experience has generated some ideas and raised some interesting questions for further exploration. The answers to these questions can only be provided through rigorous research. The research, in turn, will point the way for clinicians designing effective treatment models and for educators suggesting prevention strategies.

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CHAPTER 5

JUVENILE SEXUAL OFFENDERS: A FAMILY SYSTEMS PARADIGM

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Interest in the area of sexual abuse and assault has significantly increased over the past 10 years. Issues of victimology are now serious clinical and research topics, and one of the results has been the expanding focus on the adult sexual offender. Recognition of the need for service and research in juvenile sexual offenses has been much slower to gain the recognition and attention the field requires.

An accurate number of adolescent sex offenses is not available, although various sources show that adolescent males account for a range of 21 to 30 percent of rape (National Crime Survey 1979; Uniform Crime Report 1980). Both these sources account for forcible rape and do not measure the number of youth involved in child molesting, exposing, voyeurism, and acquaintance or "date" rape.

Services for and research on this population are important for several reasons. First, juvenile sexual offending behavior often reflects the early stages of an ongoing pattern of sexual offense as an adult. The data to support this view come primarily from retrospective, self-report studies of convicted adult sexual offenders indicating that nearly 50 percent committed their first offense during adolescence (Groth et al. 1982). Evidence of escalation from nonviolent sex crime during adolescence to serious sexual offenses in adulthood also exists (Longo and McFadin 1981). These data are consistent with information from the University of Washington Juvenile Sexual Offender Program. From a sample of 440 males with a mean age of 14.7 years, 65 percent had committed a sexual offense prior to the referring offense. Victim agencies are also documenting that adolescent offenders account for

one-quarter to one-half the reported offenses (Sexual Assault Center, Seattle, Washington; and Children's Hospital, Washington, D.C.). These data suggest that a portion of adult offenders begin a pattern of sexually offending behavior during adolescence, as well as acknowledging that sexual offenses by youth are not the exception. The necessity for effective clinical intervention and research cannot be overstated.

Since the field of adolescent sexual offenders is relatively new, there are no models of conceptualization and etiology available. A sound paradigm is essential in assessing the sexually offending adolescent and in planning intervention strategies. The lack of a framework is both exciting and potentially difficult. While the field is open to original thinking, the tendency to adopt adult models of sexual offense in assessing and treating adolescents is a concern. The literature on adult sexual offenders is vast and ranges from analytical interpretations to behavioral orientations. Psychoanalytical theory may offer explanations for sexual deviancy, but it does not offer a treatment plan with measurable outcomes. Family systems theory does not hold the offender accountable and also does not assess for a pattern of sexual offense outside the family. Behavioral intervention offers specific treatment with measurable outcome, which makes it attractive to some clinicians. However, it is a theory that is limited to a linearly based cause-and-effect model that categorizes all sexual offenders as sexual deviants. Finkelhor offers a more complex, four-factor theoretical model of adult pedophilia that deals specifically with pedophilia and builds on an integrated theory of the strengths developed in other models (Finkelhor and Aroji 1983). Given the richness of the work started on understanding the psychology of the adult sexual offender, it is important for the adolescent specialist to recognize that adolescents who commit sexual offenses are in their own unique stage of development that must be incorporated in building a theoretical model. The challenge is to identify youth who are at risk of continuing their sexually assaultive behavior and to intervene before the behavior becomes chronic and another generation of adult sexual offenders is produced.

The majority of studies on juveniles are retrospective descriptive studies of convenience samples of convicted adolescent sexual offenders, usually without comparison

groups or adequate description of the criterion offending behavior. There is rarely a recognition in these studies of the broad variety of subtypes of sexual offending behavior or of the possibility that some offenders have a pattern of general, nonsexual delinquency, while others have a pattern of only sexual offenses and otherwise bear little resemblance to adolescents who display a chronic pattern of general delinquency. Few studies attempt to identify systematically the formative and maintaining influences on the offending behavior, much less design their study with the objective of evaluating a theory-based explanatory model.

Some agreement exists, however, regarding certain facts about juvenile sexual offending behavior. First, juvenile sexual offending behavior is not a unitary class of behavior. At the very least, a distinction needs to be made between relatively noncoercive, somewhat passive, sexual assault between an adolescent and often a younger child on one hand and, the more threatening and aggressive sexual assault on the other (Deisher 1982; Groth 1977; Shoor 1966). Other types of juvenile sexual offending behavior identified in these studies include the adolescent offender whose mental illness is apparent in the act (Shoor 1966); the adolescent offender who has no physical contact with the victim (e.g., indecent exposure, stealing underwear, or peeping; Deisher et al. 1982); and the adolescent sexual psychopath who displays a general pattern of aggressiveness, manipulativeness, and lack of guilt or remorse (Markey 1950). Evident is a need to establish a comprehensive typology of juvenile sexual offending behavior, a typology that provides a theoretically sound basis for understanding the antecedent and consequent events surrounding the offending behavior.

Second, the studies of juvenile sexual offending behavior are virtually unanimous in identifying the family as a crucial influence in the development or elicitation of the offending behavior. Workers suggest a variety of mechanisms ranging from increased family trauma (Markey 1950), to failure to provide adequate emotional support (Maclay 1960), to confused family relations, including unwitting parental participation in the offense or seductive maternal behavior (Shoor 1966), to abuse by parents (Lewis 1979), and to scapegoating within the family (Deisher 1982). A recent study suggests that the number of family crises

reliably differentiates the juvenile sexual offender from the nonoffender delinquent (Ageton 1983). Denial and minimization by parents of the adolescent's previous sexual offenses are also frequently mentioned (Deisher 1982; Groth 1979).

Research from general juvenile delinquency may well be considered in building a model for the juvenile sexual offender. Several studies suggest a relationship between family functioning and general delinquency. A 5-year study of children who exhibited antisocial behavior (i.e., lying, truancy, and stealing) showed that an increase in the number of antisocial behaviors correlated with parental rejection of the child (Langer 1979). Further studies demonstrate that parents of juvenile delinquents have poor family management skills and show the importance of family functioning variables in predicting delinquency (Farrington 1972; Loeber 1983). Predictions of adult criminals were more accurate when based on home atmosphere variables than on the adult's juvenile criminal record (McCord 1979). None of the studies categorized sexual offending behavior, and whether juvenile sexual offense is similar to juvenile delinquency is open to question. Yet the role of the family cannot be ignored by adolescent specialists, regardless of what aspect of the family they wish to emphasize.

The Juvenile Sexual Offender Program at the University of Washington is a community-based evaluation and treatment program that began 7 years ago, when the sexual abuse field had no models for working with this population and when the "It's just experimentation" and "Boys will be boys" assessment approach prevailed. At this point the program has evaluated and treated over 600 adolescents who are referred mainly by Children's Protective Services and juvenile court. While officially the ages extend from 12 to 18 years old, clients as young as 8 who have exhibited aggressive sexual behaviors have been accepted into the program.

A brief description of the clients seen in the program, based on a sample of 305 males between the ages of 11 and 18, breaks down to 23 percent committing rape, 57 percent committing indecent liberties, 11 percent exposing themselves, and 18 percent committing voyeurism, peeping, stealing women's underwear, and other "nuisance" acts.

Twenty-two percent of the rape and 37 percent of the indecent liberties occurred while babysitting. Overall, 85 percent of the victims were known to the offenders, and 34 percent were relatives. Fifty-three percent had a prior sexual offense, and 44 percent had prior nonsexual offenses. The victims' interpretation of the degree of force indicated that 33 percent reported physical force was used and 12 percent threatened force or weapons; 22 percent continued the offense after the victims' expression of hurt.

The conceptual model used for assessment and treatment by the Juvenile Sexual Offender Program draws from two areas: the first considers the adolescent within a developmental framework, and the second is a family model that addresses the structure of the family as a growing and changing system.

Several typical case examples follow that indicate the need to include an assessment of the family of the juvenile sexual offender.

> Jerry, age 14, was legally charged with breaking and entering and was found nude in the home of a neighbor. He left when confronted by the woman. Jerry has a 2-year history of exposure and peeping. The latest incident is an escalation of his previous offenses. Jerry has an identical twin brother, who has been involved with some of the peeping with his brother. It is significant to consider why Jerry was identified as the offender and not his brother. The evaluation of the family included his mother and father and 17-year-old brother and revealed that Jerry was the scapegoat in this family. When he and his brother took a book from an aunt, Jerry "stole" it and his brother "borrowed" it. Other interesting factors include Jerry's father offering that he always had a fantasy of flashing, so he could understand his son's behavior without approving of it. Further, the family described their home as having no doors except in the bathroom and a curtain on the parents' bedroom because it's being remodeled (for the past 10 years). The hypothesis is that this family has no boundaries and that messages about sexuality from father to son encourage the sexual acting-out on some level.

John, age 16, has a 3-year history of masturbating with his sister's and mother's underwear. He came to the attention of the court for breaking and entering to steal women's underwear. The family includes his parents, and his 18-year-old and 11-year-old brothers. The family has known of John's behavior for the last 2 years and offered to buy him underwear so he wouldn't have to steal it. Two years ago the father moved out of the bedroom. The 11-year-old son sleeps with his mother alone after sleeping with both parents since birth. Mother states she can't tell John and her husband apart. The hypothesis is that parents do not have appropriate boundaries with sons, who get mixed messages about sexuality. The mother is enraged at the father and directs her anger at her son, who does not overtly confront her.

The assessment component is crucial in determining the risk that this client will sexually reoffend. The assessment involves approximately 4 hours of clinical interviews, including individual and conjoint sessions; psychological testing, including the Minnesota Multiphasic Personality Index (MMPI) for youths 14 and up, the Rorschach Inkblot Tests, the Thematic Apperception Test, the Incomplete Sentences Blank, the Family Adaptability and Cohesion Scale (FACES) for the family, and the Dyadic Adjustment Scale (DAS) for the parents; and collaborative information from the school and the courts. The victim's statement is crucial in addressing the minimization and denial many offenders maintain. The youth's abstract knowledge of the behavior is explored. At 12 years old, responding with, "What I did was wrong because I wasn't married" has different implications than if a 17-year-old responds with that statement. The evaluation process considers the age difference between the victim and offender, the number of victims, the duration of assaultive behavior, the nature of the abuse, the type of force involved, evidence of escalation, the history of victimization of the offender, and masturbatory and nonmasturbatory fantasies. Other assessment issues include academic history; history of delinquency and aggressive behavior in school, at home, and in the neighborhood; peer relationships (looking for a pattern of playing with younger children); drug and alcohol usage; and evidence of impulsive behavior.

The family unit including all the siblings is included in the assessment. How the parents have responded to their son's behavior is important, as it will reflect how the offender responds. Do they minimize the offense? Do the parents insist their other children not be told? If the offender has victimized smaller children outside the family, not telling younger siblings may put them at risk for sexual victimization. How willing are the parents to monitor their son's behavior? History of violence in the family and sexual abuse of family members is explored. The underlying hypothesis is that what is not working in the family system has created the environment for adolescent sexual assault to occur (see appendixes A and B for assessment outline).

Disposition of the case is by consensus of the Juvenile Sexual Offender Program (JSOP). The client is twofold, including, first, the adolescent and his family and, second, the community. What is the risk that the adolescent will sexually reoffend? Does the client require institutionalization for the safety of the community? Certain variables (i.e., use of a weapon or threat of a weapon) and an aggressive, predatory assault require serious consideration of placement in a secure facility. Overall, the lack of knowledge about the etiology of this behavior and what predisposes continuance of the behavior hampers a scientific assessment of the probability of reoffense. The JSOP has developed decision-making criteria (see appendix C) to assess risk with the question of what the risk is that this adolescent will reoffend in the next 2 years without treatment.

Adolescent sexual offenders who engage in nonaggressive acts may be considered for treatment in the community. Aggressive sexual offenders are referred to institutional settings. Rather than the legal terms of rape and indecent liberties, which reflect plea bargaining instead of behavior, the continuum on the following page is used to characterize offending behavior.

Treatment at the Juvenile Sexual Offender Program uses group and family therapy. The group members are offenders who have committed a variety of hands-off and hands-on offenses, as well as offenders in institutional settings. Briefly, group goals are to facilitate the adolescents' understanding of their sexual offense behavior both

emotionally and cognitively. The group is process oriented and co-led by a male-female cotherapy team for a 6-month period. An adolescent whose family is not willing to be in concurrent family treatment is not accepted into group therapy. Family therapy goals are individualized for each family, but generally the expectation is to facilitate appropriate boundaries between family members and to increase flexibility, cohesiveness, and nurturance, as well as acceptance of individual differences. Specific issues of scapegoating the adolescent sexual offender and sexuality and aggression are important focuses. Family typologies are needed, as well, so that etiological factors can be addressed.

Sexual Offense Continuum

Nonaggressive hands-off

Exposure, voyeurism, obscene phone calls and letters, masturbating with women's underwear

Aggressive hands-off

Breaking and entering for the purpose of stealing women's underwear, any activity from first category that increases victim proximity

Nonaggressive hands-on

Fondling, oral-genital contact, may include penetration, uses authority as older person to gain access to victim, proximity

Aggressive hands-on

Fondling, oral-genital contact, penetration, uses force, weapon or threatens to, doesn't stop with victim distress

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Clinical work with this population has created a seeming plethora of issues. Basically, if prevention of sexual abuse is a priority, research with juvenile sexual offenders can provide answers so that primary prevention efforts can be designed. Several specific questions arise: (1) Why does

a particular adolescent engage in a sexual offense as opposed to nonsexual delinquency such as theft? (2) What causes a less coercive versus a highly coercive sexual offense? (3) Why does the offense occur when it does? (4) To what extent does the family impact the development of an adolescent sexual offender? (5) What causes some adolescents to develop a pattern of sexual deviancy while some do not? (6) What is the impact of the juvenile justice system? While our individual biases are rooted in clinical experience and how we theoretically understand human behavior, the necessity for multitheoretical investigations with the juvenile sexual offender is a priority in the sexual abuse field.

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APPENDIX A

Juvenile Sexual Offender Program
University of Washington--Adolescent Clinic

Sexual Offense Assessment Questions

1. Where did you get the idea to do it?
2. What were you thinking (or fantasizing) about when you decided to sexually abuse her/him?
3. How did you pick the victim?
4. Do you think the victim wanted to do it? How do you know?
5. Who else would you have picked if she/he wasn't there?
6. How many times, when did it start, where did it take place?
7. Did the victim cry or ask you to stop? Did that surprise you?
8. What did you do when she/he cried or asked you to stop? How did you stop? Why didn't you do more with the victim?
9. Why didn't you do it more often?
10. What do you think is wrong with this behavior?
11. What do other people think is wrong with this behavior?
12. Why are there laws against it?
13. How did the victim feel? How do you know? What did the victim enjoy about the sex abuse?
14. What did you do to the victim?
15. Did you have an erection? Ejaculation?
16. What part did you enjoy?
17. How did you make sure the victim would not tell?
18. Who else did you abuse?
19. How often do you masturbate? How old were you when you started?
20. What kind of fantasies do you have when you masturbate?
21. What kind of fantasies do you have when you are just daydreaming?

Sexual Offense Assessment Issues

1. How is the reality of the offense being dealt with, i.e., court, CPS?
2. What is the age difference between the victim and offender?
3. What is their social/power relationship?
4. What type of sexual activity is exhibited? Does it reflect knowledge that is advanced for the age of the sex offender?
5. Does the sexual activity have any symbolic meaning?
6. Determine degree of denial or minimization.
7. Evaluate for evidence of a developing pattern of deviant sexual behavior, i.e., repetitive nature of offense, fantasies, number of offenses, number of victims.
8. Level of control sex offender has of his/her sex offense behavior.
9. Determine absence or presence of predatory behavior.
10. Evaluate for evidence of increased aggression or victim involvement.

APPENDIX B

Juvenile Sexual Offender Program
University of Washington--Adolescent Clinic

Family Assessment Issues

I. Sexual Offense and Sexuality

1. History of sexual or physical abuse in the nuclear and extended family.
2. How sexuality is handled, level of comfort.
3. Each family member's opinion of the sex offense and what they think should be done as a consequence.
4. Level of denial or minimization of the sex offense by each family member.
5. Which family members know about the sex offense, and who does not?
6. If the victim is in the family, how will she/he be protected?
7. Can the parents control the sex offender's access to other victims or potential victims?
8. Who are potential victims in the family?

II. Family Structure

1. Flexibility regarding situational and developmental issues.
2. How family decisions are made.
3. How family members disagree and argue.
4. How affection is shown.
5. Who speaks for whom.
6. Who protects whom.
7. Secrets, what the family does not discuss.
8. Level of comfort with individual differences.
9. Recognition of conflicts and differences.
10. How much input from outside of the family is allowed.
11. Strength and consistency of the parent/executive system.

12. How or if the children detour the conflict between the parents.
13. Who else is closely involved with the family, i.e., church, grandparents, etc.
14. Determine intrafamilial alliances.
15. Strength of boundaries between generations.
16. Overt and covert family rules.
17. Strength of sibling subsystem.
18. What is not working in the system that is producing sexually abusive behavior.

APPENDIX C

Juvenile Sexual Offender
Decision Criteria
Juvenile Sexual Offender Program
University of Washington
Seattle, Washington 98195

Instructions: The following criteria are to be used as clinical guidelines in evaluating the juvenile sexual offender. The criteria relate both to risk for offending as well as appropriateness of outpatient versus residential treatment.

Code "1" if item is true, "0" if item is not true, and leave blank only if information is missing.

LOW RISK

___ 1. First documented offense, without evidence of a developing pattern
___ 2. Offender willing to explore offense in a non-defensive manner
___ 3. Offender acknowledges and understands the negative impact of the offense on victim (empathy)
___ 4. Offender willing to accept responsibility for committing the offense without blaming others or circumstances
___ 5. Offender is guilty and remorseful because of the negative impact of offense on victim
___ 6. Offender understands the exploitative nature of the offense and reasons for its wrongfulness
___ 7. Offender admits to committing entire offense for which he was charged
___ 8. Offender has healthy attitudes about sexuality
___ 9. Offender has no history of behavior disorder involving physical aggression
___ 10. Offender has adequate social adjustment, including presence of a peer support group and participation in peer group activities

___ 11. Offender has no history of behavioral and/or academic school problems
___ 12. Parents/guardians acknowledge and understand the negative impact of the offense upon victim
___ 13. Parents/guardians hold adolescent responsible for offense without externalizing blame onto others or circumstances
___ 14. Parents/guardians acknowledge adolescent committed entire offense for which he was charged
___ 15. Family supportive of treatment and willing to become involved in therapy
___ 16. Family identifies problems within family unit and among members other than the deviant sexual behavior of offender
___ 17. Offender's family unit is functional

MODERATE RISK

___ 1. Offender has committed two or more documented offenses
___ 2. Discontinuation of offense behavior if/when victim showed distress
___ 3. Offender resists describing and exploring offense in a non-defensive manner
___ 4. Offender does not understand the exploitative nature of the offense or reasons for its wrongfulness
___ 5. Offender minimizes the negative impact of the offense on victim (little empathy)
___ 6. Offender has little or no guilt or remorse because of the negative impact of the offense on victim
___ 7. Offender externalizes blame for offense onto others or extraneous circumstances
___ 8. Offender minimizes extent of involvement in the offense, admitting to only part of the offense
___ 9. Offender resists participation in the evaluation without refusing altogether
___ 10. Offender has negative self-esteem
___ 11. Offender has depressive symptomatology
___ 12. Offender has unhealthy attitudes about sexuality

___ 13. Offender has been a victim of sexual or physical abuse, though this has not been a chronic or repetitive pattern
___ 14. Offender has a history of behavior disorder involving physical aggression
___ 15. Offender shows poor social adjustment, including isolation from peers and few peer group activities
___ 16. Offender has history of behavioral and/or academic school problems
___ 17. Parents/guardians minimize the negative impact of the offense on the victim
___ 18. Parents/guardians externalize blame for offense onto others or extraneous circumstances
___ 19. Parents/guardians minimize extent of offender's involvement in offense, holding him responsible for only part of offense
___ 20. Parents/guardians are resistive to participation in the evaluation without refusing altogether
___ 21. Mother or father is a sexual offender
___ 22. Mother or father has been a victim of sexual and/or physical abuse
___ 23. Family unable to identify problems within family unit or among members other than the deviant sexual behavior of offender
___ 24. Family is dysfunctional in response to transient situational factors

HIGH RISK

___ 1. Offender has been treated for commission of a previous sexual offense
___ 2. Offense was predatory
___ 3. Offense was ritualistic
___ 4. Offense was sophisticated, involving precocious knowledge of sexual behavior
___ 5. Offense resulted in physical injury to the victim
___ 6. Offense was associated with the use of drugs or alcohol
___ 7. Offense involved violence, physical force, use of weapon, or threat to use a weapon
___ 8. Continued offense behavior despite victim's expression of distress
___ 9. Evidence of progressive increase in the force used to commit repeated offense

___ 10. Offender completely refuses to participate in the evaluation
___ 11. Offender completely denies the referral offense
___ 12. Offender engages in compulsive masturbatory fantasies involving deviant sexuality or offense behavior
___ 13. Evidence of thought disorder
___ 14. History of firesetting
___ 15. History of torturing animals
___ 16. History of chronic substance abuse
___ 17. Offender has been a victim of chronic and repetitive sexual and/or physical abuse
___ 18. Parents/guardians refuse to participate in the evaluation
___ 19. Parents/guardians deny that offender committed the offense
___ 20. Parents/guardians deny that offender has any psychosocial problems
___ 21. Offender's family unit is chronically dysfunctional

___ Code risk for re-offending: (1) low risk, (2) moderate risk, (3) high risk
___ Code prognosis/amenability of treatment outcome: (1) good, (2) fair/moderate, (3) poor
___ Code disposition: (1) outpatient family therapy at CDMRC, (2) group therapy at CDMRC, (3) individual therapy at CDMRC, (4) group home placement, (5) correctional institution, (6) outpatient treatment referral to facility other than CDMRC

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(Note: This is not a validated research tool.)